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*Colorado Annual Session Highlights*


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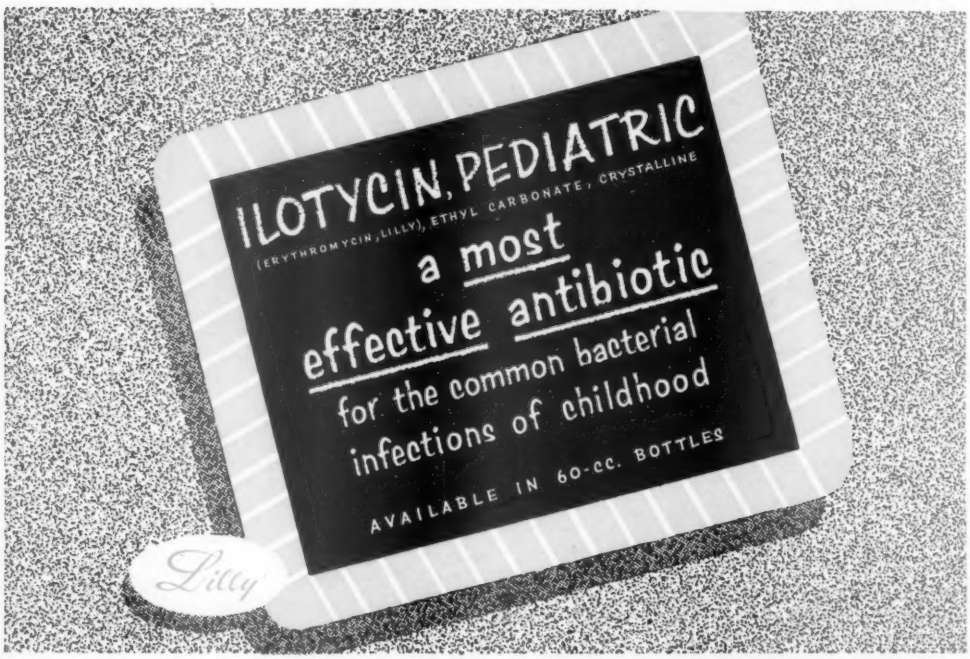


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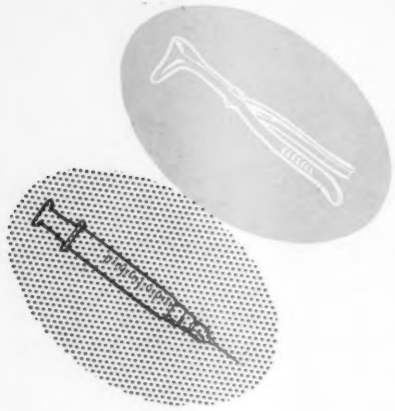

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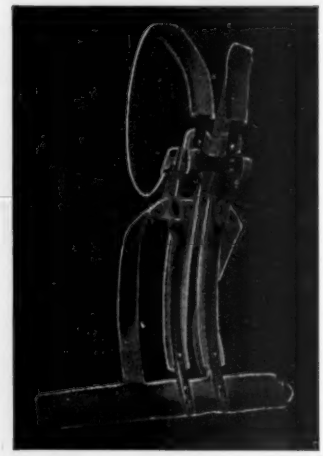

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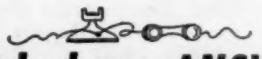

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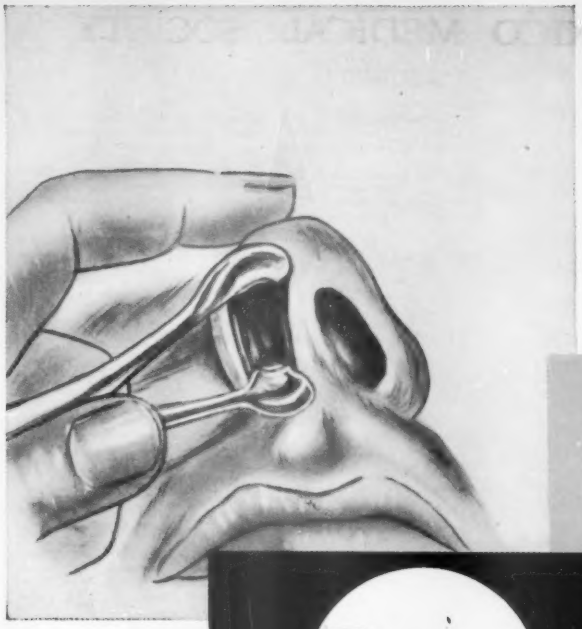

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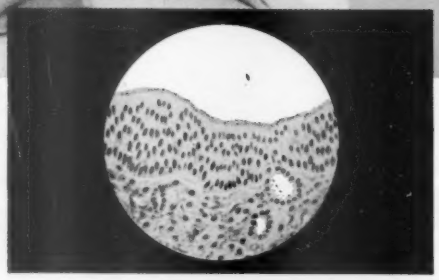

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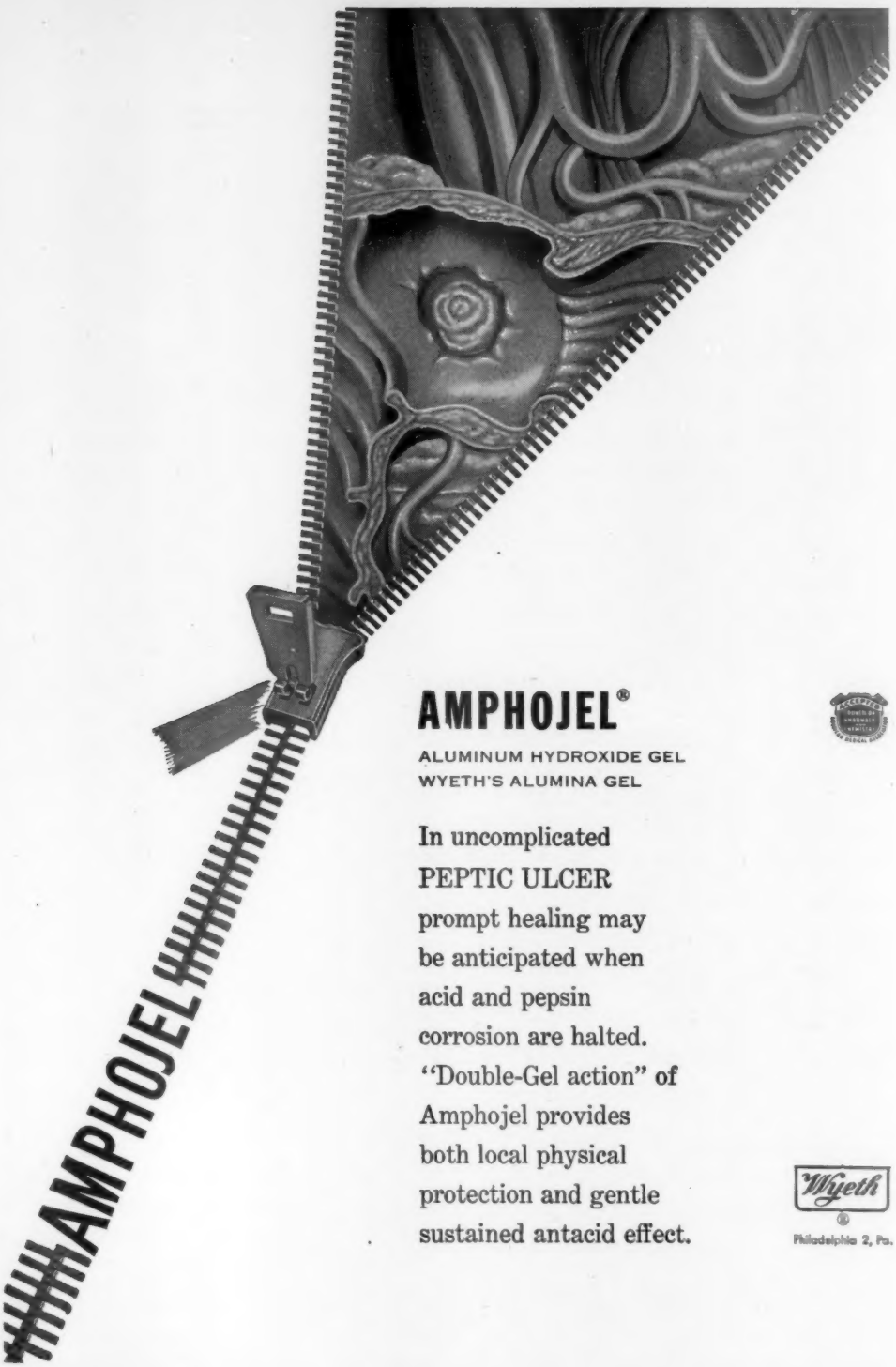


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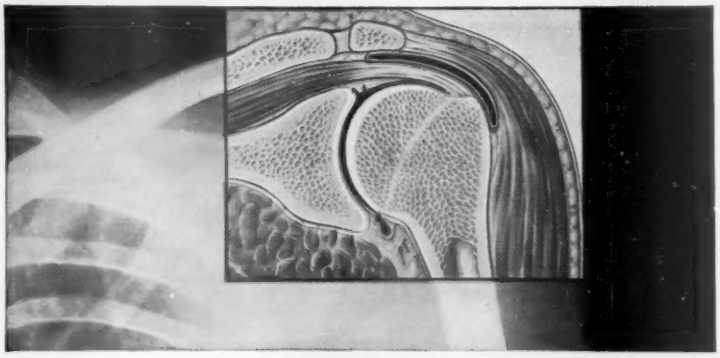

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# THE WYOMING STATE MEDICAL SOCIETY

## NEXT ANNUAL SESSION: SHERIDAN, JUNE 7, 8, AND 9, 1954

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**Executive Secretary:** R. A. Pontow, Colorado General Hospital, Denver.
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**Delegate to American Hospital Association:** Hubert Hughes, General Rose Memorial Hospital, Denver.
**Alternate:** Louis Liswood, National Jewish Hospital, Denver.

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**Legislative:** Hubert Hughes, Chairman, General Rose Memorial Hospital, Denver; Msgr. John R. Mulroy, Catholic Hospitals, Denver; DeMoss Taliaferro, Children's Hospital, Denver; Roy Anderson, Presbyterian Hospital, Denver; Jacob Horowitz, M.D., Denver General Hospital, Denver; Henry Hill, Weld County Hospital, Greeley.

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**Program:** Sister Marie Charles, Chairman, Glockner-Penrose Hospital, Colorado Springs; C. F. Fielden, Jr., Memorial Hospital, Colorado Springs; Charles K. LeVine, Beth Israel Hospital, Denver.

**Public Relations:** Charles K. LeVine, Chairman, Beth Israel Hospital, Denver; G. A. W. Currie, M.D., University of Colorado, Colorado General Hospital, Denver; Louis Liswood, National Jewish Hospital, Denver; H. G. Eichman, Boulder Sanitarium and Hospital, Boulder.

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**Rates and Charges:** DeMoss Taliaferro, Chairman, Children's Hospital, Denver; Msgr. John R. Mulroy, Catholic Hospitals, Denver; Roy R. Prangley, St. Luke's Hospital, Denver; Elton A. Reese, Alamosa Community Hospital, Alamosa; Roy R. Anderson, Presbyterian Hospital, Denver; Daniel P. Ryan, St. Joseph's Hospital, Denver.

**Hospital and Professional Relations:** G. A. W. Currie, M.D., Chairman, Colorado General Hospital, Denver; Richard Connor, Coordinator, Sisters of Charity, 1654 Fillmore, Denver (Residence); Elton A. Reese, Alamosa Community Hospital, Alamosa; Lloyd Florio, M.D., Denver General Hospital, Denver.

**Resolutions:** Daniel P. Ryan, Chairman, St. Joseph's Hospital, Denver; Alvin A. Riffel, Community Hospital, Monte Vista.

**Appointment to Committee on Careers in Nursing:** G. A. W. Currie, M.D.

**Appointment to Colorado League of Nursing Nominating Committee:** Observer, Roy R. Anderson.

**American Legion:** Henry Hill, Hubert Hughes.

# Meat...

## *and the Important Role of Protein in Hemoglobin Synthesis*

Although the relationship between iron and hemoglobin formation is widely appreciated, the important role played by protein in hemoglobin synthesis is relatively obscure. Nevertheless, since globin is just as much a component of the hemoglobin molecule as is iron, the continued synthesis of this protein is necessary for normal hemoglobin production.

It has recently been estimated that in the average adult 8 Gm. of globin is destroyed daily.[1] This means "that approximately 14% of the total dietary protein intake of the average adult [female] is required solely for the re-synthesis of new hemoglobin. These data reemphasize the importance of adequate protein, as well as iron, intake for the maintenance of a normal rate of hemoglobin synthesis in man."[2]

Because meat is an outstanding source of *both* iron and high quality protein, it is always recommended in generous amounts in the dietary management of hypochromic anemia. These nutritional values, as well as its significant content of B vitamins, also make meat an important component of the daily diet of normal persons.

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1. Drabkin, D. L.: Metabolism of Hemin Chromoproteins, Physiol. Rev. *31*:345 (1951).
2. The Biosynthesis of Hemoglobin, Editorials, J.A.M.A. *150*:1223 (Nov. 22) 1952.

The Seal of Acceptance denotes that the nutritional statements regarding meat made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

**American Meat Institute**
**Main Office, Chicago... Members Throughout the United States**

When patients are sensitive to antibiotics al

# always consider ERYTHROCIN*

A SELECTIVE ANTIBIOTIC

**ORALLY EFFECTIVE**

against staphylococci, streptococci and pneumococci—especially indicated when patients are allergic to other antibiotics or when the organism is resistant.

**A DRUG OF CHOICE**

against staphylococci—because of the high incidence of staphylococci resistant to other antibiotics.

**A DRUG OF CHOICE**

because it is less likely to alter normal intestinal flora than other antibiotics, except penicillin; gastrointestinal disturbances rare; no serious side effects reported.

**USE ERYTHROCIN**

in pharyngitis, tonsillitis, otitis media, sinusitis, bronchitis, scarlet fever, pneumonia, erysipelas, pyoderma and certain cases of osteomyelitis.

**DOSAGE**

average adult dose is two 100-mg. tablets every four to six hours. Specially-coated ERYTHROCIN tablets are available in bottles of 25 and 100. Abbott

*Trade Mark ERYTHROMYCIN, ABBOTT CRYSTALLINE

Conclusive evidence

of the effectiveness and low toxicity

of Furadantin

in treating bacterial urinary tract infections

is provided in its recent

acceptance by the Council

.....FURADANTIN®..

brand of nitrofurantoin

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The N.N.R. monograph on Furadantin states:

"**Nitrofurantoin.—Furadantin (Eaton).—**

*Actions and Uses.*—Nitrofurantoin, a nitrofuran derivative, exhibits a wide spectrum of antibacterial activity against both gram-positive and gram-negative micro-organisms. It is bacteriostatic and may be bactericidal to the majority of strains of Escherichia coli, Micrococcus (Staphylococcus) pyogenes albus and aureus, Streptococcus pyogenes, Aerobacter aerogenes, and Paracolobactrum species. The drug is less effective against Proteus vulgaris, Pseudomonas aeruginosa, Alcaligenes faecalis, and Corynebacterium species; many strains of these organisms may be resistant to it. However, bacterial resistance to other anti-infective agents is not usually accompanied by increase in resistance of the organisms to nitrofurantoin. The drug does not inhibit fungi or viruses.

Nitrofurantoin is useful by oral administration for the treatment of bacterial infections of the urinary tract and is indicated in pyelonephritis, pyelitis, and cystitis caused by bacteria sensitive to the drug. It is not intended to replace surgery when mechanical obstruction or stasis is present. Following oral administration, approximately 40% is excreted unchanged in the urine. The remainder is apparently catabolized by various body tissues into inactive, brownish compounds that may tint the urine. Only negligible amounts of the drug are recovered from the feces. Urinary excretion is sufficiently rapid to require administration of the drug at four to six hour intervals to maintain antibacterial concentration. The low oral dosage necessary to maintain an effective urinary concentration is not associated with detectable blood levels. The high solubility of nitrofurantoin, even in acid urine, and the low dosage required diminish the likelihood of crystalluria.

Nitrofurantoin has a low toxicity. With oral administration it occasionally produces nausea and emesis; however, these reactions may be obviated by slight reduction in dosage. An occasional case of sensitization has been noted, consisting of a diffuse erythematous maculopapular eruption of the skin. This has been readily controlled by discontinuing administration of the drug. Animal studies, using large doses administered over a prolonged period, have revealed a decrease in the maturation of spermatozoa, but this effect is reversible following discontinuance of the drug. Until more is known concerning its long-term effects, blood cell studies should be made during therapy. Frequent or prolonged treatment is not advised until the drug has received more widespread study. It is otherwise contraindicated in the presence of anuria, oliguria, or severe renal damage.

*Dosage.*—Nitrofurantoin is administered orally in an average total daily dosage of 5 to 8 mg. per kilogram (2.2 to 3.6 mg. per pound) of body weight. One-fourth of this amount is administered four times daily—with each meal and with food at bedtime to prevent or minimize nausea. For refractory infections such as Proteus and Pseudomonas species, total daily dosage may be increased to a maximum of 10 mg. per kilogram (4.5 mg. per pound) of body weight. If nausea is severe, the dosage may be reduced. Medication should be continued for at least three days after sterility of the urine is achieved."

The NITROFURANS
A unique class of antimicrobials

EATON Laboratories Inc.
NORWICH, NEW YORK

## ANSWERS TO COMMON QUESTIONS

# about 'Ilotycin'

(ERYTHROMYCIN, LILLY)

***Q. What is the status of 'Ilotycin' in the treatment of pneumonia?***

In pneumonia caused by pneumococci and staphylococci, 'Ilotycin' is very effective. Doses of 200 mg. every four hours are recommended.

***Q. Is 'Ilotycin' effective in urinary tract infections?***

Yes, when the causative organism is susceptible to its action and when there is a minimum of mechanical factors such as strictures, stone, and the like.

***Q. How long should a streptococcus throat infection be treated with 'Ilotycin'?***

The recommended minimum course for any antibiotic is five days. 'Ilotycin' completely eradicates the organisms within five days and thereby prevents recurrence of the infection.

***Q. Is there any contraindication to the use of 'Ilotycin' immediately following a parenteral dose of penicillin?***

No. 'Ilotycin' does not inhibit the activity of penicillin. There is probably no specific indication for using penicillin in addition to 'Ilotycin.' Experiments both in vitro and with animals have shown no evidence that 'Ilotycin' is either antagonistic to or synergistic with penicillin or the "mycins."

***Q. Are coliform bacteria less sensitive to 'Ilotycin' than to other "broad-spectrum" antibiotics?***

Yes. There is less possibility of monilia and fungus overgrowth in the intestinal tract with 'Ilotycin,' since the predominant organisms of the normal intestinal flora are relatively insensitive to the antibiotic action of 'Ilotycin.'

**'Ilotycin' is supplied in 100 and 200-mg. specially coated tablets . . . at pharmacies everywhere.**


Lilly THE ORIGINATOR OF ERYTHROMYCIN

Rocky Mountain Medical Journal

Colorado
Montana
New Mexico
Utah
Wyoming

NOVEMBER
1953

# Editorial

## *Utah Stages a Great Rocky Mountain Conference*

THE Rocky Mountain Medical Conference marked another milestone in Salt Lake City in September when its seventh biennial session was combined with the annual meeting of the Utah State Medical Association. This was the first meeting of the Conference under its new system of being merged, so far as the scientific session is concerned, with the annual session of the host state.

The plan proved eminently successful. A total of 788 physicians were registered, about twice as many as would normally attend an annual meeting of the Utah Association alone, and the registrants came not only from all the Rocky Mountain states but from many other states as well. Total registration figures for all persons participating in the Conference have not been compiled, but will be well over the thousand mark. Those who missed this meeting really missed something!

This was also the first meeting of the Conference without a registration fee, and the Utah committees in charge report happily that in spite of the reduced income, the Conference this year will probably show a small "net" above expenses. Luncheons, banquets, and parties were all made self-supporting this year, and the balance of the income came from forty-four technical exhibits, manned by 175 representatives of leading pharmaceutical and supply firms.

The event was highlighted by the presence of Dr. Edward J. McCormick, President of the American Medical Association, and seven other guest speakers, all of whom appeared before the Conference both in person and through the medium of closed-circuit color television, the latter feature being supplied by the Smith, Kline and French Laboratories. Public health broadcasts over regular television and by radio were given by all of the guest speakers several times within the week.

Several presentations by guest speakers at this Conference will be published in succeeding months in the Rocky Mountain Medical Journal.

The Continuing Committee of the Conference has selected Albuquerque for the next biennial meeting, to be held in May, 1955, the exact dates to be announced later. Dr. H. L. January of Albuquerque will be General Chairman for the 1955 meeting, and the Continuing Committee very properly extended a hearty vote of thanks to Dr. U. R. Bryner of Salt Lake and his many local committees for staging an immensely successful Conference this year.

## *Danger Signs*

A REPRESENTATIVE group of business and professional men were gathered about a banquet board at the annual meeting of their country club. Needless to say, the physicians hadn't been there long before they were talking shop. This time the economic side was "getting the works." Collections, taxes, forms and more forms to fill out, meetings and more meetings to attend, undependable employees, unreasonable and unreasoning patrons—all were in the line of fire. But governmental interference and competition with the individual soon loomed forth as the greatest evil and foreboding threat. Over two score agencies are administering medical care, the largest single example being the Veterans Administration which admits liability for medical and hospital care to over twenty million adults, and

the number is increasing by a million per year.

Another gentlemen approached and sat down, soon to be asked the nature of his occupation. He is an oil executive who thought we really wanted to know when someone said, "How's business?" After a relatively brief summary, which added up to "not so hot," he said that if the government doesn't get its fingers out of his field, it's sunk. Another clubman, previously silent, averred that this fact goes for him too—he's in the transportation business. And then another, a cattle broker, said he and his colleagues are in the same boat but right now it looks as though it might be too late. Maybe they're already sunk. The doctors, at least for once, were silenced, not to be heard from again for several minutes.

Look about at our fellow men and at our government. The individual isn't as big as he used to be, and the government is bigger and becoming more so. The trend is not good; it must be reversed if catastrophic and dismal failures similar to those of old world countries are to be avoided. We must leave the business men, financiers, farmers and others to wage their own—and remarkably similar—battles. But as to ourselves and our profession, let's make voluntary health insurance work; let us, as individuals and as a profession, give the patient what he has every right to expect. And let us forever practice according to the Golden Rule: When we do these things, voters themselves will see to it that control of our own profession will be left to us.

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*Announcement*

IT IS with very deep regret that your Editorial Board announces the resignation of Miss Helen Kearney, who for many years had been Business Manager of the Rocky Mountain Medical Journal, this being part of her position as Assistant Executive Secretary of The Colorado State Medical Society. She left our employ September 25, 1953.

Miss Kearney began her association with this Journal as a part-time editorial and business assistant in 1926, when the Journal was known as "Colorado Medicine." Since then she has served and worked closely with a total of five different Scientific Editors, one Managing Editor, and, since 1947, with an Editorial Board of ten members. She became a full-time employee of The Colorado State Medical Society in October, 1929, and a few years later was appointed Assistant Executive Secretary of the Society and Business Manager of the Journal. Through three years of World War II, while the Executive Secretary-Managing Editor was in the Army, she assumed most of his duties as well as her own.

Especially during those war years, when so many of the younger and more active physicians were away in the Service, it fell to Miss Kearney to carry on the major part of the management of the Journal, in addition to her increased duties relating to all of the manifold activities of The Colorado State Medical Society. Dr. John S. Bouslog and the author of this little piece, who was then Acting Editor of the Journal, are perhaps in better position than anyone else in knowing the added burdens she assumed, and the credit which she deserves for the manner in which these burdens were borne and carried out. The value of her services were of the sort for which no payment of money could adequately compensate.

In 1946 the House of Delegates of The Colorado State Medical Society awarded Miss Kearney the first "Certificate of Service" issued by the Society to any person other than its Past Presidents, commemorating her "completion of twenty years of loyal service," and at the same time accorded her a memorable ovation.

We of the Editorial Board wish for Helen Kearney the best of everything, and we know that hundreds of our colleagues throughout this region join us in regretting that she felt it necessary to leave us.

LYMAN W. MASON, M. D. Chairman,
Editorial Board.

# Original Articles

## PRESIDENTIAL ADDRESS*

CLAUDE D. BONHAM, M.D.
BOULDER

As I stand before your during these first few moments following my induction into the Presidency of the Colorado State Medical Society, I am deeply grateful for the great honor you have bestowed upon me in elevating me to this position and I am acutely aware of the responsibilities which go with it. As I review the names of the many men who have preceded me in the Presidency I am awed by the work which has characterized their administrations and I am proud of my association with the members of this State Medical Society, who have by their accomplishments showed the way to the solution of many of the problems besetting the medical profession. It is my humble prayer that you will continue to give your cooperation in making this coming year one which will show a continuing progress in solving the present day problems facing us.

Across the broad space above the massive doors of the Norlin Library on the campus of the University of Colorado, there is inscribed in letters of stone a brief and succinct statement of fact which we all could do well to consider. It says "He Who Knows Only His Own Generation Remains Always A Child." In these few beautifully phrased words one can see man in his beginning making efforts to learn by his own experience first and then learning by the experience of his forebears so that he could survive his time.

With this method of learning, as civilization made its march from his day to ours, the truth of the oft repeated statement that we must unite in order to survive has been proved over and over again. Its truth was more specifically underscored in the early days of our own American Revolution when one of the leaders of that movement exhorted his fellows to "all hang together lest they each hang separately." Those men, by following the exhortations of their leader, were the ones from whom we obtained the liberty and freedom we now enjoy.

It is easy to stand united when there is a common cause to be defended. This was illustrated by the reaction which occurred within the medical profession when the liberty and freedom of our members were threatened by the forces seeking to socialize our profession. Before these forces began to come out in the open with their proposals, Medicine was complacent and individualistic almost to the point of abstraction. We were too busy, we told ourselves, to take part in any of the affairs of our community, our state or our nation other than those dealing directly with clinical medicine. These, we kept telling ourselves, were the most important of all the sociologic occurrences going on around us and if we could only continue our uninterrupted interest in such things we would be serving the public in their best interests.

Then came the awakening!

As the result of our own self-examination in the light of cold, factual public opinion we were astounded to find that these assumptions upon which we had depended for many years were not necessarily true. Recognizing this, we became galvanized into action and the result of that action has brought about one of the most noteworthy changes of attitude within the ranks of medicine. United and concerted action became the rule and the fight to stem the tide of the socializers turned in our favor through a totally new alignment of that same public opinion which had not been so favorable only a short time before. This new alignment of public opinion was arrived at only

*Delivered October 2, 1953, before the Eighty-third Annual Session, Colorado State Medical Society, Shirley-Savoy Hotel, Denver.

through our uniting ourselves, first for our own education regarding the basic fundamentals involved in the fight against socialization and second in our concerted efforts in educating the general public regarding the facts behind the entire program.

Each of you will recall that with this improved and enlightened public opinion, the later actions taken by our Congress on those bills having to do with socialization were entirely favorable to Medicine.

It was not long after that, however, that some of the spokesmen for Medicine felt that they should publicly proclaim their political prowess. It was then that some rather unbelievable things began to happen. One of the most noteworthy was a statement made to the public press that Medicine had at last fought the foe in the form of socialized medicine and had won, and that the evidence showed that this problem would never again become serious.

That statement alone was soon found to be the cause of the lag in interest by many physicians who had previously fought well during the heat of the campaign. This fact was soon recognized by the more astute leaders and was corrected immediately because the statement was entirely untrue.

These leaders had learned in their primer of political maneuver that a victory such as ours meant only that those favoring socialization would begin to divide and conquer by breaking up into smaller components the entire program as it had been presented and defeated, and presenting it in small parts and in disguised forms and having it pass the Congress with little or no fanfare.

The short interval of peace and relative security was interrupted, however, by what now seems to appear to be one of the major problems along this same line. It was with relatively scant attention that the program of the present administration, as presented to Congress in the name of general economy, brought to light a disapproval of the size of the appropriation proposed for the Veterans Administration. A great deal of reaction did come from Veterans Administration circles which at first seemed not related to our present discussion, but it was soon found that here indeed was a place where attention should be paid regarding the general program of veterans' care.

A study was instituted by the American Medical Association which has now been published in condensed form. Copies have already been distributed to your House of Delegates and will soon be available to all physicians. As the study points out, the care of service-connected disabilities has never been questioned and we have all agreed that such conditions should be taken care of by the federal government through the Veterans Administration. The medical profession has always pledged itself to provide the best medical care possible for these veterans with service-connected disabilities. But the Veterans Administration has not spent its money for such service-connected disabilities alone. Instead, 85 per cent of the present veterans care program is being given to the care of non-service-connected disabilities in the veterans facilities.

Now this has all come about quite legally but it is unbelievable that it has grown to the present proportion without having been more positively challenged long before this.

Prior to 1923, all Veterans Administration care was given only to service-connected disabilities, but in that year, due to a reduction in the patient load in this category, some beds became available, and by the Act of March 4, 1923, Congress authorized care of the veterans of the Spanish American War, the Philippine Insurrection and the Boxer Rebellion suffering from neuro-psychiatric or tuberculous diseases, whether or not service-connected. Very shortly after that it became necessary to increase the hospital facilities by construction of new hospitals. Three years later, on July 2, 1926, another act was passed by Congress which extended the privileges of hospitalization and medical care, where existing facilities were available, to the veterans of any war, military occupation or expedition, who were not dishonorably discharged, without regard to the nature or origin of those disabilities. This law qualified approximately five million men and women veterans for free hospital and medical care for life, at public expense, and resulted in a huge influx of veter-

ans into government institutions. This act of 1926 was repealed by the "Economy Act of 1933" and by this repeal the situation of chaos was temporarily halted.

Since 1934, hospitalization and medical care have been granted to (1) veterans with disabilities attributable to service in the armed forces and (2) to veterans with non-service-connected disabilities, within limits of existing facilities, if such veteran is unable to pay for private care.

This latter group of non-service-connected disabilities is admitted after the veteran has signed a statement declaring that he is unable to pay for private hospital and medical care. It seems that there has been no effort made to determine whether this is a true statement of fact or not and the result has been that this so-called "paupers oath" has been signed by many veterans who have been known by those outside the Veterans Administration to be easily able to pay for their care. Yet the oath was signed and accepted without any question or investigation. In fact, when this situation was brought to the attention of the Veterans Administration they insisted that they were without power or authority to make any investigation beyond seeing that the oath had been signed by the applicant for care.

So by increasing the number of eligible entrants for veterans hospitals and medical care, all of the present existing facilities have repeatedly become overburdened and requirements for further hospital construction have been met by succeeding Congressional action in the provision of more funds for expanding facilities in order to take care of not only the honest service-connected disabilities of its veterans but to take care of those who are not entitled in any way to the care available through those facilities.

Where, you may ask, is all of this expansion leading us? What is the situation regarding the number of units operated by the Veterans Administration and how many beds do those units provide? A report based on information available up to July 31, 1952, showed that the Veterans Administration operated 154 hospitals. Of this number, 100 are general medical and surgical hospitals, twenty are for tuberculosis patients and thirty-four are for neuro-psychiatric patients. These 154 hospitals comprise a total of 116,986 beds or an average of 759 beds in each hospital. But this is not the entire story. At the same time the Veterans Administration was in the process of constructing eighteen new hospitals and making additions to four existing hospitals, which would add 13,231 more beds. In addition to this, were six new hospitals totaling 5,000 beds which were in the advanced planning stage. If we add these we come to a total figure of 135,217 beds in 182 hospitals, to which should be added also seventeen domicillary units with an additional 17,443 beds for a grand total of 199 units furnishing 152,660 beds.

Coming back to the number of veterans in the present population of 160,000,000 people in the United States, we find that there are now, as of August 31, 1953, 20,000,000 veterans of military service. This represents 40 per cent of the total adult male population of the United States. It is also found that there are approximately 80,000 veterans of military service being added to this total each month, so that we may rightly become alarmed when we total these figures because it is apparent that it will not be very many years until the veteran population will be almost equal in numbers to the non-veteran population.

By even the most elementary calculation it can be seen that if the present rule for eligibility is followed there will be still further additions to the existing facilities, as well as still further additions to the veteran population, and care will be given to that group of "special citizens" to the extent that it will actually amount to the almost total socialization of medical care in the United States.

By equally simple calculation it can be noted that the present existing facilities in the Veterans Administration would be entirely adequate or more than adequate to care for all of the existing service-connected disabilities for many years to come even after adding those which may require institutional care as the veteran population increases in age.

Efforts have been made in the recent past

to arrive at a solution of this problem by conversations and discussions with the various veteran groups over the country. There has been, to some extent, a fair agreement on certain points, but in the main it seems that most recently there has been a definite breach in the negotiations with these same groups, to the point that it now becomes necessary that we must make a bold stand and implement it, first by education of our own membership and secondly by public education in a manner similar to that taken during the program on socialized medicine a few years ago.

Thus, what started out to be a relatively small problem has actually, upon study, showed itself to be one of the major approaches to socialization of medicine as we recognize it today. This all adds up to the need for the medical profession to again unite itself in an active and vigorous campaign which may well extend, not over a few months but perhaps over several years. In this campaign we must know what we are fighting for and, with our ideals of the past held as high as ever in our minds as regards public good, it is not at all questionable that thorough and vigorous approach to this problem will find an answer which can be utilized in the public good and again Medicine will be saved from socialization.

During the past ten days, in cooperation with the retiring administration, your present officers have taken immediate steps which will serve to quickly organize our forces along these lines and will, we hope, promptly enable us to support the campaign at our state and local levels here in Colorado in cooperation with the over-all campaign now in the process of development through the American Medical Association.

Another very important problem which faces us as medical men is civil defense. True, we are all acquainted with the fact that there has been a great deal of outward apathy on the part of the public as a whole in preparation for civil defense against atomic attack, but we as medical men must recognize the absolute necessity of our being specifically and thoroughly prepared to meet a contingency. Of all non-military groups of citizens, medical men make up one of those important groups having to do with civil defense, who are able and willing to recognize the serious dangers inherent in the event of attack. It is most necessary that we, in spite of the public's apathy, make a specific effort to train ourselves in the things which will be necessary for us to do in the event of such an atomic attack. The uncertainties going with the present international siutation make it imperative that we recognize the dangers of attack, especially within our own borders. It is not so much that some of our smaller communities will be themselves attacked but that the larger community of metropolitan Denver would be a major target and we on the outside must be prepared to help evacuate and give necessary medical and hospital care to the evacuees from the stricken area.

In some communities in the state there have been active preparations begun for just such training and those doctors and nonmedical people are to be congratulated for their efforts. It is very necessary that each one of us, regardless of how remote our own community may be from the possibility of atomic attack, should prepare himself to help in the care of those people who may be evacuted from the center of atomic destruction to our communities for definitive care.

One of the first questions to come up during the initial discussions of this problem locally has been that of stockpiling of medical supplies in the community. It is impossible to cover the technics that are involved in such supply of every community with such materials, but suffice it to say that there will be available to major and minor communities over the entire United States a supply which will be adequate for the subsequent care of a basic number of victims of atomic attack. Although that phase of the problem is a very major one, this is not the way medicine should prepare itself to meet the problem. We should organize temporary hospitals with listings of equipment available in the community in the form of beds, blankets and other necessary materials for the establishment of such hospitals, plus organization of the personnel available so there will be present and ready for action medical teams, nursing teams, hospital helpers and all forms of conveyances and fa-

cilities for emergency communications so that movement of evacuees and supplies can be facilitated. This major problem warrants your individual interest and enthusiastic support in your own community because without it we may be found lacking and at the time of attack there will be no time for preparation. Civil defense must be met realistically by Medicine!

Another much more personal problem has presented itself during the past year. Many of us were jarred into vocal protest when we received the bill for the coming year's coverage from our professional insurance carriers. We were shocked to find that our previous rates, which we thought were high enough, already were being raised very materially in all categories. Many questions were asked and much study was undertaken in cooperation with the insurance companies themselves, and it was found that coverage for professional liability was necessarily being boosted, first because of the increasing number of suits against physicians for damages for one cause or another and second, because the amounts allowed by juries in settlement of all damage claims, including medical claims, had been more than normally increased. All this added up to the demand for higher rates by the insurors. Studies are still being carried on as to ways and means of meeting this problem with less costly outlay of the premium dollar. That, however, is much less likely to be successful than would be a program of our own self-discipline under which we would first recognize that our own careless words to an already disgruntled patient may be the trigger mechanism which will later lead to suit either against ourselves or, worse yet, against another physician. It behooves us to zealously guard our tongues because that is the basis of many such suits.

In April of this year one of the major labor leaders of this country appeared before the national meeting of Blue Shield-Blue Cross to discuss Labor's part in the health and hospital insurance program of the nation. After praising the expansion and the forward-looking programs of both Blue Shield and Blue Cross in their respective fields, he voiced the opinion that if Labor were unable to soon find an over-all coverage of every contingency of illness, accident or time loss of the worker and members of his family at a very much reduced rate than now available, that Labor itself would have to consider the unpalatable but necessary possibility of supporting the drive for socializiation of medicine and its ancillary services. In further support of his contention, he cited several instances of what might be considered inadequacies of medical and hospital care in local areas and inequities in the charges made for such services. In the main he contended that Medicine was inclined to charge more than the public could afford to pay and therefore was pricing itself out of a normal market. He cited the relative insurance rates of coverage for many of the physicians' charges and showed that there is a great discrepancy in the amount ordinarily charged to an uninsured person, leaving out the fact that the insurance was never intended in the first place to pay for any individual's full coverage for any type of loss, but only was intended to cover a portion or a relative part of the cost of that potential loss.

Our reaction to these contentions perhaps would be, first, that it was an unfair charge that we are pricing ourselves out of a normal market, especially in view of the fact that in the main our fees have gone up less, percentagewise, than any charges for any other type of personal service now available, including the cost of labor. On the other hand, we might say that it is a totally uninsurable situation to take care of every contingency, that that would not be basically insurance. That contention is true. On the other hand, the reconciliation between the demand for full coverage and the demand for less cost again shows that there has been a lack of study and factual evidence considered by those making the demands. Still further, we would be inclined to say, and quite rightly and quite proudly so, that our own Colorado Medical Service is now coming more nearly to the goal of complete family coverage by the offering of the new preferred plan, which is now available and which covers groups up to $4,500 in our State.

Regardless of the way in which we look at

such demands, whether we feel that they are reasonable or not, we must admit that the problems they bring up are a challenge to Medicine and the ancillary services of Medicine and will have to be answered at some time in the future. We therefore should be thinking in terms of such demands and laying our plans to meet, or even forestall, if possible, such demands as might arise in this connection.

It must certainly seem to you that the future is deeply concerned with nothing but problems of one or another kind from what has been outlined here. We must remember, however, that our long period of formal and clinical training has prepared us as no other profession or business is prepared for the solution of problems great or small, in the realm of life and health. Surely you can see as I do that these problems mentioned here are but challenges to our citizenship in our local communities and our state and nation and should pose no insurmountable difficulties to our conditioned minds if only our hearts are added and we give our closest scrutiny, our deepest thought and consideration and our best effort at a solution that will be satisfactory both to the public and to Medicine. We know that our interest has always been and will always remain first for the patient and the public at large.

It shall never change unless and until a false or altered philosophy is forced upon us.

## RETIRING PRESIDENT'S ADDRESS*

KENNETH B. CASTLETON, M.D.
SALT LAKE CITY

At the close of my term of office as your President I am glad to have this opportunity of expressing my appreciation to the members of this Association for the privilege of serving as your President during the past year. It has been a most interesting experience, at times trying and discouraging, at other times stimulating and gratifying.

It seems fitting at this time to review our activities of the past year, and then to point out some of the things that I have learned and make a few suggestions for the future. We have had a very active year. We have attempted to carry on the affairs of our organization according to the highest traditions of our profession. We have continued many of the projects of our distinguished predecessors and have inaugurated several new ones in an attempt to keep our organization abreast of the times.

Probably the most significant single project which we have introduced is the publication of the Bulletin. We believe that it is helping to unite our membership better than ever before and is keeping it better informed regarding activities of our State Association, the A.M.A., the component societies, legislative news of both our State Legislature and Congress, and also news regarding the Medical School, future meetings, and personal items. Its inception was modest but it has grown beyond our expectations. It has received fine support not only from the profession but from the advertisers, to whom we owe much for its success, and it has received favorable comment nationally. Most of the credit for its success must go to Harold Bowman who has managed it almost single-handedly, although we must give credit to our Editorial Board which has faithfully reviewed the material before publication. The Bulletin is not meant to be a scientific journal or to replace the Rocky Mountain Journal, which remains our official journal. We sincerely hope that the Bulletin has met with the approval of our members and that they will continue to give it their support.

I would next like to mention our legislative program. This year we carried on an active and successful campaign in our own legislature to promote the passage of several bills designed to improve health conditions in this state. Specifically, the principal bills were:

1. The Water Pollution Bill. The purpose of this bill is to prevent pollution of the waters of the state, especially those used

*Delivered September 9, 1953, before the 59th Annual Meeting, Utah State Medical Association House of Delegates, Salt Lake City.

for culinary purposes, but also those used for irrigation purposes. As most of you know, there is widespread contamination of our waters. Many communities are drinking water which does not come up to the minimum requirements of the U. S. Public Health Service, and nearly all irrigation waters of the state are grossly polluted by raw human sewage. This bill became law and we believe it will be a major step towards solving the water pollution problem.

2. A bill to revise the Health Code of the state. The Health Code was in great need of modernization and strengthening. That portion pertaining to the regulation of hospitals was of particular interest to us, and although the bill was passed with some amendments, it nevertheless will aid in the elevation of hospital standards and in improving public health.

3. We suported the request of the University of Utah College of Medicine for more funds to build a new medical building. The amount granted the school was far below the amount requested, yet an increase was provided in the budget and also some funds alloted which will lead to a new building before many years. This was accomplished for other state schools.

We also gave strong support to a bill to provide a coroner's office in this state. This bill failed of enactment, due, we believe, to misunderstanding on the part of those who opposed it.

Much credit for our legislative program should go to our Legislative Committee, headed by Dr. Charles Ruggeri, Chairman.

Our Utah Health Council Committee has done a fine job in promoting the radio and television programs, which have now spread to cover nearly all stations in the state. This project has been well received and has been accorded high praise from A.M.A. headquarters. It has been accomplished at comparatively small cost in proportion to the value of radio and TV time utilized. The Committee on Radio, TV and Press is promoting good relations with these powerful groups and has prepared a "Code of Cooperation" to govern our ethical relations with them.

Our School Health Committee has worked with other agencies on matters pertaining to the health of school children and has done much to retain the examination of school children in the hands of the family doctors where it belongs.

We have a committee to provide bi-weekly health articles for the newspapers of the state, and although this project was delayed for some time, it is now functioning and we are desirous of obtaining the reaction of our members throughout the state, especially in the rural areas.

The Committee on Sewage and Water Pollution has prepared several excellent articles to aid the doctors in providing leadership in their own communities in their efforts to obtain pure water and to provide for the proper disposal of sewage.

Our Committee on Insurance Problems has met with insurance groups to discuss mutual problems and to attempt to solve them. Much good has been accomplished but there still remain many problems of a mutual nature and I feel that this committee should continue its work.

A very large part of our activities should be placed under the category of Public Relations. Indeed, this probably constitutes the largest single item in our activities. This field is so broad that it involves the activities not only of our Public Relations Committee but almost every other committee in our organization. Much of the time of the Council has been devoted to this field, and although the projects in this category are too numerous to report at this time a few will be briefly mentioned.

We have urged our members to take a more active part in civic projects, Chambers of Commerce, civic organizations and clubs, church activities, veterans organizations and public health projects. We feel that we must provide leadership in many fields where we have previously taken no part or have followed passively. Even in matters of public health such as water supply, milk supply, tuberculosis, etc., we have done little in the past, being content to leave these matters to the U. S. Public Health Service or to our own State Board of Health. Our influence should be felt in civic groups and in veteran organizations in order that these organizations may receive the benefit of our experience and training so that our profession might aid them in the formulation of poli-

cies which will be to the advantage of the general public.

Our Board of Supervisors has done an excellent job. It has investigated and satisfactorily solved several difficult problems within the profession. The members of this Committee have spent many long hours at great personal sacrifice to accomplish this, and we of the Association owe them a great debt of gratitude.

There are many other activities but time will not permit a discussion of them. Among them are the activities of the Committees on Civil Defense, Cancer, Rural Health, Mental Health, Fee Schedule, Industrial Health, Medical Education and Hospitals, and others.

I am pleased to report that at the A. M. A. meeting in New York in June this state was given an Award of Merit for its excellent response in the American Medical Education Foundation drive, and we have received commendation on several occasions for our activities in public relations, radio and TV, etc. We have been in rather intimate contact with our congressional delegation regarding several pieces of national legislation affecting the medical profession, and on numerous occasions have sent telegrams and letters to our congressional delegation expressing our views on such matters as the Jenkins-Keogh Bill, the Bricker Resolution, the medical care of veterans, etc.

I have an award here (displaying document) given to us for our work in the American Medical Education Foundation.

This provides in brief the principal activities of your Association during the past year, but before closing I would like to mention a few projects which I feel might deserve your attention for the future. First, I would urge your continued interest in public relations with its many ramifications. Next, I would urge that some plan be inaugurated for the indoctrination of new members in our Association. This matter has already been discussed by our Committee on Medical Education and Hospitals. Many young doctors know little or nothing about the ethics of our profession, how to set up an office, how to call in a consultant, what to do if a patient comes in who is under the care of another doctor, etc. A better understanding of these problems would help our own interprofessional relations as well as our public relations.

Another worthwhile project would be the dissemination of information to the public regarding the reasons for the high cost of medical care and the high cost of hospitalization. This matter has also been brought before one of our Committees: the Committee on Medical Economics.

I would urge establishing and maintaining further liaison with the commercial insurance companies, with the hope of improving the hospital and medical insurance policies which are sold to the public. We would render a real public service if we could establish definite criteria for these policies and publicize them so that the public might use them as a guide when purchasing insurance of this type.

A more intimate liaison with the other professions, especially nursing, dentistry, law and pharmacy, is desirable, and it might be well to set up an inter-professional committee to accomplish this.

I would recommend that our dues be increased $20.00 per year and this money earmarked for the American Medical Education Foundation.

It has already been proposed that the membership of the Board of Supervisors be increased. This I heartily endorse and in line with the recommendations of the A.M.A., I feel that its name should be changed to the Professional Relations Committee.

I think that we might well consider changing the time of our State Meeting from fall to spring, so that resolutions from our State Society to the A.M.A. might be carried by our delegate to the Annual Meeting of the A.M.A., which is held early in June. At present, with our State Meeting in the fall a resolution to the A.M.A. has to wait three months for the A.M.A. Clinical Session Meeting, or nine months for the Annual Meeting.

We might consider reclassification of our membership in order to provide some relief in the payment of dues, particularly to full-time teachers in the Medical School who are on a relatively low salary and who do not

qualify for associate membership according to our present Constitution and By-Laws. I am thinking principally of a full-time instructor who is making $4,000 a year, who has four children and who feels he cannot afford membership in our organization. We need those men and I believe some provision should be made to include them in our organization.

We should work with the American Legion and other interested groups in helping to solve some of the problems pertaining to medical care of veterans. There is no doubt that there are many abuses regarding the care of non-service-connected disabilities in veterans. There are likewise many misunderstandings and much misinformation, and I am sure that many of these problems could be resolved by cooperative action.

I feel that we should take an active part in the problems of the Salt Lake County Hospital since it is more than a county problem, affecting as it does the Medical School and patients from various parts of the State. This is an opportunity to render a public service and your Council is studying this problem at present.

I heartily endorse the proposal to increase the size of the Council by the addition of a councilor from each component society. These should be elected for a three-year period and the terms of office staggered.

Finally, I would like to take this opportunity to thank all of you who have cooperated so magnificently in the activities of the State Association this year. Although I cannot begin to mention all of you or to give all credit where it is due, I want to especially thank Dr. George Fister, our delegate to the A.M.A.; Mr. Harold Bowman, our Executive Secretary; Dr. John Z. Bowers, Dean of the Medical School; Mrs. Cutler and others in the office; Dr. George Spendlove and the other members of the State Health Department, and especially the members of the Council. I believe that the Council is the best the Association has ever had. It has been an honor and a pleasure to serve with them.

We have had some critics but in the main the criticism has been constructive and this type of criticism is always welcome. To those who have had nothing to offer except destructive criticism, usually based on misinformation or incomplete information, I can only say that I hope you will take a more active part in our Association in the future. It will be an education experience for you. To all of those who have contributed to the year's activities we owe a great debt of gratitude.

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# SPINAL NERVE ROOT PAIN*

TRACY R. LOVE, M.D.
DENVER

Spinal nerve root pain is one of the serious problems with which the medical profession must contend. Surgical relief is dramatic in certain cases, but the majority of patients with nerve root pain do not belong in the surgical category. It is justifiable, therefore, to bring to your attention the use of a comparatively new drug, non-narcotic in character, which has given remarkable relief to patients suffering with nerve root pain. This drug is known as Protamide†. This is a sterile collodial solution of a processed and denatured proteolytic enzyme which is extracted from fresh hog stomach. It has been shown by Lehman, et al.,[1] that the substance is non-toxic, producing no deleterious hemolytic, hemodynamic, or anaphylactic changes even on slow intravenous infusions. The usual dose is 1.3 c.c. given intramuscularly.

Protamide is recommended for relief of viral diseases such as herpes zoster[2,3], and chicken pox[4]; and it has been used with encouraging results in treatment of lightning pains of tabes dorsalis[5]. These facts suggested the idea that Protamide might give relief from nerve root pain due to spinal arthritis; and in December, 1951, such an investigation was started. Since then, in addition to cases suffering nerve root pain from

*Presented before the Eighty-Second Annual Session, Estes Park, Colorado, September 9-12, 1952.
†Protamide (trade mark), Sherman Laboratories, Detroit 15, Michigan.

arthritis, cases of nerve root pain due to other causes have also been treated, including two with malignant bone metastases. A brief report of twelve cases treated with Protamide follows.

**CASE 1**

R. M., male, aged 50. Marked arthritis of the lumbar spine with moderate deformity was shown by x-rays. In December, 1951, after heavy lifting, patient developed severe pain in the left gluteal region, over the crest of the ilium, and down the left leg. The first injection of Protamide gave much relief; and after the third injection, patient returned to work. Some pain persisted, but he has remained greatly relieved. Inquiry on September 8, 1952, reveals that he has worked continuously ever since.

**CASE 2**

A. R., male, aged 45. Patient contracted an acute respiratory infection including bronchitis. He developed pain in the left axilla and the third left interspace with some tenderness to pressure. The pain was intense on coughing. There were no friction sounds, and the x-ray of chest was negative for pneumonia, but it showed slight arthritic changes in the upper dorsal area. The pain had been constant for six weeks, with partial relief with empirin and codeine. He was confined to his bed. Six hours after the first injection of Protamide, the patient had his first night's relief from pain. After the third injection, the pain was entirely gone and the man returned to work.

**CASE 3**

M. H., female, aged 50. This patient developed pain down the left thigh, leg to foot, with some tenderness to pressure over ankle. She had not suffered any previous respiratory infection. Pain had been present for several weeks. One injection of Protamide gave marked relief; and since the second injection, there has been no further trouble. Report on September 8 indicated no recurrence of pain.

**CASE 4**

L. S., female, aged 67. This patient has had moderate arthritis, especially of the knees and ankles, for many years. She suddenly developed severe pain in the left knee after tripping on the stairs. The pain extended down the anterior tibial region to the ankle, and there was tenderness to pressure over the lower tibia. Patient was given one injection of 1.3 c.c. of Protamide intramuscularly. This brought great relief from pain. This injection was followed by three more at weekly intervals, and the severe pain has entirely subsided. The patient has remained fairly comfortable to the present time.

**CASE 5**

L. W., male, aged 40. While lifting a door, patient strained his back and almost immediately developed a backache. The following day patient developed severe pain below both knees over anterior and inner aspects. The pain became progressively worse, and by evening it was so severe that he could not remain in any one position for any length of time. He was given a dose of Protamide that evening, and within two hours he noticed marked relief from the severe pain. He was able, the next day, to continue his work. A second dose twenty-four hours later gave further relief, but the results were not as dramatic as those following the first dose. The pain and the backache entirely disappeared in about ten days and have not recurred to date.

**CASE 6**

A. R., female, aged 44. This patient has had arthritis of the spine for many years, has undergone long treatment with salicylates, and has worn spinal support with only fair results. X-rays showed old spinal arthritis. Sciatic pain was the common manifestation of her pathology. The recent complaint was that of pain in the left lower abdomen which could not be explained by pelvic or abdominal pathology, as none could be found on examination. The lower abdominal muscles seemed somewhat tender to pressure. The patient was given 1.3 c.c. of Protamide intramuscularly. This brought marked relief from pain, and two days later a second injection was given which gave complete relief from the abdominal pain and tenderness. Ten days later, pain and tenderness on pressure developed below the left breast, and a single injection of Protamide brought complete relief. At the same time, the pain along the sciatic nerve had disappeared. Since these injections, the patient has been busy about her home, doing considerable work in the garden, and has had some mild arthritic pains but no severe attacks since.

**CASE 7**

E. N., female, aged 50. This patient has had arthritis of the spine as shown by x-ray, and complained of severe pain in the left knee. The pain on two occasions has become very severe, and she was confined to bed because of this pain. There was no abnormality of the knee, and motion of the knee was without pain; but on flexing the thigh over the abdomen, intense pain was produced, as was the case on standing. One single injection of Protamide gave great relief, and it has been repeated from time to time when the pain became great.

**CASE 8**

G. W., male, aged 68. Occupation, fireman. This patient had old, hypertrophic arthritis of the spine as demonstrated by x-ray. After unusual effort he developed severe pain in the hip and left thigh. Patient experienced great relief after a single injection of Protamide, and three injections brought such relief that he returned to work.

**CASE 9**

B. G., female, aged 58. Patient was first seen in March, 1952, complaining of a severe pain in the lower right chest. The pain followed the ninth and tenth intercostal nerves and extended to the midline, causing upper abdominal pain and tenderness. The skin was tender and the subcutaneous tissue also. However, there was no rash. The condition was considered to be herpes zoster without rash, and three doses of Protamide gave marked relief; but the patient still had low back pain which was intensified by motion. X-ray of the lumbar spine was said to be negative. Two months later the pain developed around the region of the left breast, in the left arm, and down the left leg. There was tenderness to pressure in the left chest. Electrocardiogram was negative. Two doses of 1.3 c.c. each of Protamide gave complete relief.

**CASE 10**

A. P., male, aged 55. Patient developed pain in the upper lumbar area on the left side. The pain seemed to be due to arthritis of the upper lumbar spine, since bending the spine intensified

the pain. There had been no respiratory infection. Patient was given three injections of Protamide with great relief from the pain. The pain disappeared entirely in a few days.

### CASE 11

A. W., female, aged 72. In 1943, the left breast was amputated for malignancy. Patient was first seen in February, 1951, at which time she was complaining of vague pains in the upper right abdomen and pain on motion of the right hip. She was coughing, and x-ray showed pathology of the upper right chest which was believed to be malignant. She was given heavy doses of testosterone and returned home feeling very much better. Last October, some pain developed again in the region of the right hip and thigh, but it was not constant and was variable in severity. She was not seen again, however, until June, 1952, at which time she was suffering from a bleeding ulcer of the stomach which showed no signs of malignancy. About this same time, pain in the right leg became steadily worse but was almost completely relieved while patient was in the hospital for treatment of the ulcer, since she was in bed during that period. After patient left the hospital, the pain in the leg promptly became worse; and x-ray showed involvement of the pelvic bones and acetabulum. For the next six weeks she was receiving two injections of Protamide a week, and this has relieved the pain in the leg to such an extent that she is able to get about with reasonable comfort. She usually takes one-half to one grain of codeine at night.

Since July 28, because of gradual failure, this patient has been in Presbyterian Hospital taking 50 mg. demerol once or twice at night for general discomfort and a desire to sleep. At times she requires empirin and codeine, grain one-half, during the day; but the records show that after Protamide is given, she will go a week or more without any codeine during the day, and she suffers only moderate pain at night.

### CASE 12

R. Y., female, aged 52. Two years ago, patient had some pain in the right shin; and when she was first seen June 3, 1952, pain was most severe about the right knee, extending upward to the right hip. Heat was the only thing which had given her any relief, and she has used the electric pad so much that there was marked blotching and brown discoloration of the skin from the right sacroiliac region all around to the front of the thigh. This woman had developed bronchogenic carcinoma of the right lung, and x-ray showed metastatic involvement of the spine but nothing definite around the right sacroiliac area. She was started on Protamide without promise of relief, and she receives an injection of 1.3 c.c. twice a week. Since starting the injections, she has discarded the electric pad, and the pain is sufficiently relieved so that she looks forward to the injections. She does use some codeine, one-half grain once or twice in twenty-four hours; but, nevertheless, she depends upon the Protamide to give her great relief, and thinks the effect of the Protamide wears off in five to six days. At this date, September 8, 1952, she still insists on receiving the Protamide.

## Comment

Twelve cases of nerve root pain treated with Protamide have been reported. In six cases the pain was definitely associated with back strain (Cases 1, 4, 5, 6, 7, and 8). In two cases (Cases 3 and 10) back strain was the probable cause of pain. Case 2 followed severe respiratory infection, and Case 6 had occasional respiratory infections and chronic sinus involvement which made possible the presence of viral infection. In Case 9 the cause is unknown; but since the distribution of pain involved both right and left sides at different times without history of respiratory infection and no rash, it is possible the pain was due to mild spinal arthritis.

Cases 11 and 12 are definitely associated with bone metastases, and in neither case has there been any history of respiratory infection. Since these two cases are of such hopeless character, it is gratifying to feel that they receive considerable relief from pain by the use of Protamide.

Very recently an article by Smith[6] has appeared in which the author makes the point that the cases of neuritis due to upper respiratory infection or viral infection occurring within three weeks of onset of the symptoms were the only ones benefited or cured by Protamide. He believes these patients suffered from inflammatory involvement of the nerve roots. He further suggests that other types of radiculitis might be successfully treated with Protamide.

In the twelve cases herein reported, it is believed that, with the exception of Cases 3, 11, and 12, and perhaps Case 9, the pain was due to traumatic congestion around the nerve roots. In seven cases x-ray demonstrated arthritis or other disease of the spine.

## Summary

Twelve cases of nerve root pain due to various causes are reported. Protamide was given to each one, with complete relief of pain in five cases. In five others, all arthritics, pain has been so relieved that treatment is unnecessary at present. The two cases with malignancies are convinced that Protamide reduces the pain so much that each requests periodic injections.

There have been no unpleasant side effects whatsoever from the injections of Protamide.

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# DIABETIC LIPEMIA*

## CLINICAL SIGNIFICANCE OF THE NEWER KNOWLEDGE


BRENDAN PHIBBS, M.D.

CASPER, WYOMING


It has long been obvious that the blood sugar is not the only deranged factor in diabetes mellitus. Early in the history of the disease, it was remarked that fats in the blood stream and tissues were subject to abnormal influence. The phenomenon of frank lipemia was observed to occur in severe diabetics who had been out of control for some period of time; in these cases, the serum was observed to be actually creamy in color and consistency, due to very high levels of blood-lipids. Lipemia retinalis has been observed in such cases, and it has been noted that when control of the blood sugar was achieved, abnormal fat levels abated, as evidenced by examination of the retina and blood. Fatty infiltration of the liver, with hepatomegaly, was a common phenomenon in diabetics of the pre-insulin era, and it remained common until the introduction of protamine insulin made adequate control of blood sugar levels possible.

Finally, with prolongation of the diabetic life span which attended the discovery of insulin, it became apparent that degenerative vascular disease was the chief cause of disability and death in diabetics. Pathologic studies have made it equally apparent that fatty infiltration of the vascular walls plays a major role in production of this degenerative process. As Hirsch[1] has pointed out, analysis of the quantitative composition of fatty masses found in atherosclerotic vessels reveals an illuminating fact—the proportions of various lipids found in these masses are very close to the proportions of lipids found circulating in the blood, which suggests that the intima may be freely permeable to these fatty substances. All these facts suggest that a disordered fat metabolism may be closely connected with the disordered carbohydrate metabolism of diabetes mellitus.

A nodding acquaintance with the constituents of blood lipids is helpful in any such study. These fatty substances are divided into three categories—cholesterol, the phospholipids, and the triglycerides (fatty acids) and neutral fats. It has long been possible to measure cholesterol levels in the blood with some accuracy[2] and the earliest investigations of blood lipids used this substance as an index of lipemia. This proved barren, as it was difficult to detect significant fluctuations of cholesterol levels, even in the presence of marked lipemia. Both cholesterol and phospholipids appear to be "stable" elements, and do not often undergo any decided alterations in quantity. In animals rendered totally diabetic by pancreatectomy, for instance, it was found that cholesterol and phospholipid fractions remained unaltered, although the total lipids were elevated[3].

Recently, a colorimetric method has been devised for measurement of the triglyceride fraction of blood lipids[4]. It has subsequently been possible to study the behavior of this lipid fraction in human diabetics, with interesting results. Hirsch and co-workers[1] measured the triglyceride levels in a group of normal individuals and found that the fasting level lay between 9.2 and 12.6 mEq per liter of serum. They then measured

*Presented before the Natrona County Medical Society, February 19, 1953. From the Casper Clinic.

the fasting levels in a group of diabetics and found them in the high-normal range. These same healthy patients and diabetics were then subjected to a "lipid-tolerance" test, exactly analagous to the common glucose-tolerance test. A fatty meal, containing 2-3 gm. fat per kg. body-weight was fed, and the blood lipids were measured throughout their subsequent rise and fall. It was found that the diabetic lipid-tolerance curve tended to be higher and to remain elevated for a longer time than was the case in normal individuals. Interestingly, it was also found that the more severe the diabetes in terms of insulin requirements, the higher and more prolonged was the lipid-curve. In many of the severe diabetics, the serum was found to be creamy in color twenty-four hours after the fat-meal. In other words, gross hyperlipemia was induced in many of the diabetics studied, by a single meal of fats. In all these cases, it was the triglyceride fraction of the lipids which was elevated, while the cholesterol and phospholipids were changed little or not at all.

Is there any connection between the elevated blood sugar of diabetes and elevation of blood lipids? This question logically poses itself in the light of the above facts and becomes particularly relevant in view of the current controversy over the necessity for, or desirability of, maintenance of normal blood sugar levels.

The author, working with Hirsch and Carbonaro[5] attempted to answer this question. Insulin was withheld from groups of diabetics until a considerable elevation of blood sugar had been induced. The blood lipids were measured daily as the sugar rose. Then, after some days or weeks of hyperglycemia, the sugar was brought under control with insulin or diet or both, the lipid levels being measured daily throughout. With surprising regularity the blood lipids—the triglyceride fraction specifically —rose to abnormally high levels in parallel relation with the blood sugar and, as the blood sugar was brought to normal, the lipids again fell, almost simultaneously, to the control levels. Some of the levels attained during these test periods were striking. In one case the lipids rose 400 per cent above the control level when the blood sugar reached 350 mgm. per cent.

In a second group of diabetics, fat-tolerance curves were determined at normal blood sugar levels. Then, by withholding insulin, hyperglycemia was induced. After some days or weeks or hyperglycemia, a second fat tolerance curve was performed. In every instance, it was found that the lipid tolerance curve during hyperglycemia was much higher and more prolonged than was the case at normal blood sugar levels.

The difference in fat levels was striking. A lipid tolerance curve performed when the blood sugar levels ranged from 285 to 350 mgm. per cent showed values from 200 to 300 per cent above values found when the blood sugar was 131 mgm. per cent.

Briefly, then, whenever the blood sugar rises to abnormal levels, the blood lipids undergo a parallel and proportionate increase—hyperglycemia in the diabetic is accompanied by hyperlipemia. In addition, any prolonged period of hyperglycemia results in reduction in fat tolerance—i. e., ingestion of fat during a period of hyperglycemia results in much higher, more prolonged blood fat levels than is the case during a period of normoglycemia.

What, one asks, is the relevance of these findings to clinical management of diabetes? Two important practical conclusions can be drawn. The first has to do with the hotly mooted question of the degree of control of blood sugar necessary or desirable. Joslin, Root, and their associates[6,7] have preached for years the necessity of maintaining the blood sugar at normal levels. They maintain that the poorly controlled diabetic is much more likely to suffer vascular degeneration than is the well-managed case which has not been subjected to long periods of hyperglycemia. Statistical evidence compiled at the Deaconess Hospital, drawn from a large number of cases over a long period of time, is impressive if not incontestable.

However, Tolstoi[9] and others of his school have contended that hyperglycemia, of itself, has no significance. This laissez faire doctrine insists that if the diabetic is kept

out of acidosis, and in nutritional and electrolyte balance, his blood sugar may be disregarded and his diet may be uncontrolled. While the actual evidence brought forward to support this view is not imposing, the appeal of a "you may eat cake" philosophy to the harrassed diabetic is considerable. Proponents of the free diet have found it easy to shrug off the statistical evidence of long-term disease attending hyperglycemia, and have countered by saying that no immediate demonstrable damage to the economy of the body can be shown to follow hyperglycemia unless acidosis or dehydration is produced.

Our present knowledge of the relationship of hyperglycemia to hyperlipemia, of course, answers this latter assertion. In many diabetics, it now appears, elevation of the blood sugar brings with it a sudden rise in the blood lipids. Is such lipemia harmful? One must assume so. In view of facts earlier pointed out in connection with vascular disease, lipemia retinalis and fatty infiltration of the liver, one cannot view as innocuous a process which results in "drenching" the blood with abnormal quantities of lipid material for hours or days. The fact that diabetics commonly suffer from severe manifestations of abnormal fat metabolism is something more than coincidental with the fact that elevation of blood sugar is followed by elevation of blood fats.

The second conclusion has to do with dietary management. In the pre-insulin era, high fat diets were helpful in staving off disaster, and like many medical concepts which have outlived usefulness, the high fat diet has survived to the present, partly because of the mistaken notion that high fat diets lower insulin requirements. It has been suggested in our original publication describing this work that much atheromatous degeneration now being seen in diabetics may be in part a result of high fat diets in these patients. Clinically, a liberal carbohydrate, low fat intake has been found satisfactory in terms of immediate stabilization of the patient. There now appears to be experimental evidence for restriction of fat intake in diabetes, since fat tolerance is poor in these individuals, at best, and since any period of hyperglycemia will reduce the fat tolerance drastically.

Thus, available knowledge of the behavior of diabetic blood lipids brings the clinician circuitously around to the hard unchanging fact that the best possible treatment of diabetes is restitution of blood sugar values to normal, as nearly as possible — and by "normal," one implies a normal fasting level, as well as a normal blood sugar level within three hours after each meal. What is known at this date is not by any means the alpha and omega of pathologic physiology of diabetes, nor do the authors intend to imply that the abnormal lipid metabolism described here is the only factor in genesis of vascular degeneration of older diabetics. That it is one factor, possibly a major one, seems likely, and the phenomena we have observed appear to support, on a laboratory basis, the conclusions drawn from clinical experience and statistical analysis by many competent diabeticians.

### Summary and Conclusions

Some recent studies on blood lipids in diabetes mellitus are described. It is pointed out that:

1. The triglyceride fraction of blood lipids is the "labile" portion, which becomes elevated during periods of hyperlipemia.

2. Elevation of blood sugar for any period of time brings about a parallel elevation of blood lipids.

3. Control of blood sugar reduces blood lipids to normal, or more nearly normal, levels.

4. Fat tolerance is abnormal in diabetics, with high lipid levels present in the blood as much as twenty-four hours after a single fatty meal.

5. Fat tolerance at high blood sugar levels is much poorer than when the blood sugar is normal.

6. The possible relationship between elevation of circulating lipids and formation of fatty deposits within the intima of blood vessels is pointed out.

7. Advisability of strict maintenance of normal blood sugar levels and of a low fat intake is discussed.


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# ANTIBIOTICS—THEIR USE AND ABUSE*


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Until 1937 the treatment of infectious diseases was a relatively simple matter because, with very few exceptions, no specific treatment was available and all were treated symptomatically. Since that time, the sulfonamides and several antibiotics have been discovered which are therapeutically useful, and now we have reached the point where the choice of antibiotics has become a real problem in management of infection and, at the same time, the tendency to prescribe a drug, rather than diagnose a disease, has become much more pronounced. It is the purpose of this paper to review the effects of the various antibiotics therapeutically and to discuss the advantageous use of each.

Antibiotics may be divided into two groups from the therapeutic standpoint, those which are primarily bacteriocidal agents and those which are simply bacteristatics. Penicillin and polymyxin and, to a lesser extent, streptomycin and bacitracin, are bacteriocidal; this is to say, they actually kill bacteria, while aureomycin and terramycin act only to inhibit the growth and reproduction of bacteria, and hence are bacteriostatic agents. This is of considerable importance in choosing the proper antibiotic, because if one selects aureomycin or terramycin, then one depends on the normal body defense mechanism to actually destroy the bacteria causing the infection. In most infections this is quite dependable, but in an overwhelming infection, such as septicemia or in a patient with agranulocytosis, these bacteriostatic agents would not be effective and one should choose one of the bacteriocidal agents instead.

Nearly every clinical bacteriological laboratory now is prepared to determine the antibiotic sensitivity of a given strain of bacteria. This is a useful procedure in selecting the proper therapeutic agent, but must be interpreted carefully. The correlation between sensitivity in the test tube and in the patient is good with penicillin, but somewhat less good with the other antibiotics. This is particularly true with streptomycin, where the correlation is poor. Another factor for consideration is the probable blood levels that may be achieved with different agents. For example, it is difficult ordinarily to maintain levels of penicillin greater than 5 units per cubic centimeter of serum, while a level of 20 micrograms of streptomycin is easily obtained. Therefore, if an organism were sensitive to 5 units of penicillin and to 10 micrograms of streptomycin, the latter should be the antibiotic of choice.

In considering the uses of various antibiotics, it is appropriate to discuss each one, stressing usefulness and limitation of usefulness. These data are summed up in Table I. It will be noted that the sulfonamides have a good antibacterial effect on both the Gram-positive and the Gram-negative organisms. They are peculiarly effective against the meningicoccus and still remain the drug of choice for the management of meningicoccal infection. Because of this wide spectrum and the fact that the sulfonamides are bacteriocidal agents, they also represent useful agents in management of acute

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urinary tract infections. Bacterial resistance develops slowly if at all; side reactions are few now that we confine ourselves to the use of sulfadiazine and gantrisin and one or two others and have discontinued sulfathiazole. Side reactions are occasional skin reactions. Toxicity is moderate and is primarily nephrotoxicity and can be completely avoided in all but a few cases by insisting that the patient force enough fluids to insure a urine volume equal to or in excess of two liters per day. They are not only not useful in the treatment of rickettsial disease but are absolutely contra-indicated inasmuch as they will aggravate these diseases.

Penicillin is prescribed in the largest numerical dosage but actually represents the most potent of all the antibiotic agents. Penicillin is primarily effective against the Gram-positive organisms, particularly streptococci, pneumococci, and, to a lesser extent, the staphylococci. It is also effective against the gonococcus and the meningicoccus and is highly effective in syphilis. It is not effective in rickettsial infections. Resistance of bacteria develops slowly, if at all; side reactions are few, consisting usually of nothing more than sensitivity reactions of urticaria and occasional serum sickness, this latter occurring in few cases. The incidence of sensitivity reactions, however, is increasing and presents a strong argument against the indiscriminate use of penicillin. Its toxicity is negligible. Oral penicillin is occasionally useful in mild bacterial infections and in prophylaxis, but its usefulness is limited. For most infections susceptible to penicillin the repository penicillins are most satisfactory. These are the insoluble penicillins, either procaine penicillin or the newer Bicillin. These are slowly absorbed from muscle and give low but sustained blood levels. Procaine penicillin in doses of 300,000 to 600,000 units will give satisfactory blood levels for twenty-four hours, while 600,000 units of Bicillin will give levels somewhat lower than this but sustained for five to seven days. These preparations are not painful in injection and give no higher incidence of sensitivity than aqueous penicillin. These are adequate for treatment of most infections susceptible to penicillin, such as streptococcal pharyngitis, pneumococcal pneumonia and others. If one is dealing, however, with a severe infection, or one in which sensitivity of the organism is relatively poor, aqueous penicillin should be used. This will give high blood levels for a four- to eight-hour period, depending on size of the dose. We give aqueous penicillin never oftener than every eight hours even in the treatment of subacute bacterial endocarditis. Dosage varies from 100,000 to several million units each eight hours. If high, well-sustained levels are needed in treatment of resistant infection, one of the penicillin blocking agents may be used in conjunction with aqueous penicillin. These act by inhibiting the renal tubular excretion of penicillin. The best is Benemid, which is given in doses of 2 grams per day. This will result in a four- to eight-fold increase in initial penicillin blood level and a level sustained over a much longer time.

Streptomycin is useful against the Gram-

**TABLE I**
**CHARACTERISTICS OF THE COMMON ANTIBIOTICS**

| Drug | Gram + | Gram — | Rickettsial | Virus | Side Resistance | Reactions | Bacterial Toxicity |
|---|---|---|---|---|---|---|---|
| Penicillin | ++++ | — | — | — | Slow | Few | — |
| Streptomycin | +++ | +++ | — | — | Rapid | Few | ++ |
| Aureomycin | ++ | ++ | ++++ | + | Slow | Nausea Diarrhea | — |
| Terramycin | ++ | ++ | ++++ | + | Slow | Nausea Diarrhea | — |
| Chloramphenicol | ++ | ++ | ++++ | + | Slow | Diarrhea | ++++ |
| Bacitracin | +++ | — | — | — | Slow | Pain | ++++ |
| Polymyxin | + | ++++ | — | — | Slow | Pain Toxic psychosis | ++++ |
| Sulfonamides | ++ | ++ | — | — | Slow | Few | + |

positive organisms although not nearly so potent here as penicillin and has a vigorous activity against many Gram-negative organisms. It is effective against rickettsia and its major disadvantage is that bacterial resistance develops rapidly. This, of course, limits the length of time that this drug can be administered successfully. Side reactions are relatively few, with an occasional sensitivity reaction, and its toxicity is mild but must be considered in the long-term use because irreversible damage to the vestibular nuclei may result from too much streptomycin over too long a time. Streptomycin is particularly useful in treatment of tularemia where it has never been exceeded. Doses of 1 gram a day or less are effective. If the nodes become fluctuant, aspiration with a needle followed by instillation, under low pressure, of small amounts of streptomycin will frequently produce dramatic regression of nodes and make draining unnecessary. This antibiotic is also useful in treatment of certain urinary tract infections, pneumonias due to Gram-negative organisms, such as Friedlander's bacillus and brucellosis; in the latter, when combined with aureomycin or terramycin. Its use in tuberculosis is well known and will not be discussed here. In the administration of streptomycin, the total daily dose should be given in a single injection inasmuch as there is adequate evidence that more frequent administration has no advantage.

Aureomycin and terramycin may be considered together inasmuch as these drugs have virtually identical spectrum antibiotics and are administered orally, which represents a real advantage in their use. They are moderately effective against both Gram-positive and Gram-negative organisms and are dramatically effective in treatment of the ricket sial diseases. Bacterial resistance develops slowly; they each have a number of annoying side reactions, consisting of nausea and diarrhea but serious toxicity is essentially lacking.

Aureomycin and terramycin are useful in treatment of mild bacterial respiratory infections and certain infections caused by larger viruses such as lymphogranuloma venereum, psitticosis, and ornithosis. This accounts for its occasional beneficial effect in treatment of primary atypical pneumonia. They are, of course, the drugs of choice in treatment of Rocky Mountain spotted fever and other rickettsial infections. They have been and are being used widely in treatment of acute urinary infections but while they produce dramatic improvement initially the evidence is excellent that the relapse rate is so high that their use is in general to be condemned if any other antibiotics or sulfonamides can be used. They are used in doses of 1-2 grams per day in two to three divided doses when given orally and 0.5 grams twice a day parenterally.

Chloramphenicol, on the other hand, with the same antibiotic usefulness has recently been implicated in a number of cases of aplastic anemia. Thus, this drug should be used sparingly and only when no other drug is effective. Such an example is in the treatment of typhoid fever.

Bacitracin and polymyxin are antibiotics which have recently become available for general use. Bacitracin is highly effective against the Gram-positive organisms and polymyxin is highly effective against the Gram-negative, including pseudomonis and proteus. They are ineffective against the rickettsia; bacterial resistance develops slowly; they each have the problem of pain on injection and polymyxin is capable of producing severe toxic psychosis. Both of these substances are markedly nephro-toxic but this nephro-toxicity appears to be reversible and probably in their present form neither drug produces permanent renal damage if used cautiously and only with proper indication. The latter two drugs represent useful additions to our antibiotic armamentarium but because they are toxic, their use should be limited to an absolute indication and they should be discontinued as the situation will warrant it.

Now that we have a number of antibiotics, there is frequent tendency to combine them in treatment of any given disease. Recent evidence supplied by Lepper and Darling and others is suggestive that certain combinations are highly effective and, indeed, synergistic, while other combinations may actually be antagonistic. This is an important

consideration when one combines antibiotics. The evidence seems excellent that penicillin and streptomycin combine with synergism and that this combination makes a useful form of treatment of some severe Gram-positive bacterial infections. On the other hand, if one is dealing with an organism which is primarily sensitive to penicillin and either one of the oral antibiotics and aureomycin or terramycin are added, the result will be antagonistic to penicillin. This is suggested by the forty cases of pneumococcal meningitis reported by Lepper and Darling where twenty were treated with penicillin alone and the rest with penicillin plus aureomycin. The first group showed a mortality of 39 per cent and the latter a mortality of 75 per cent. Thus it is unwise to add aureomycin or terramycin to penicillin treatment of a patient with an infection susceptible to penicillin.

From the above discussion, it should be evident that the antibiotics are potent antibacterial agents, each having a specific area of usefulness. We have no antibiotic which is effective against all infections. It is too often felt that these agents make differential diagnosis of infectious disease unnecessary, while the opposite is true. With effective therapy available, it became necessary to make exact diagnoses and treat specifically. There are only a few infections, and those fortunately acute and easily diagnosed, that cannot wait for therapy for a few hours while an exact etiologic diagnosis is made. Failure to do this not infrequently results in greater delay in diagnosis while one is waiting to observe the effect of therapy.

## *Case Report*

### CORTISONE IN MIGRAINE AND HISTAMINE HEADACHES*

RICHARD N. FROHNER, M.D.
GREAT FALLS, MONTANA

Migraine headaches and rheumatoid arthritis share the characteristic of being alleviated during pregnancy. Since rheumatoid arthritis is dramatically relieved by cortisone, it seemed logical to try cortisone in the treatment of migraine. We have used cortisone in the treatment of twenty patients with migraine headaches over the past two years.

Nine of the patients experienced complete relief. Three patients experienced partial relief but the headaches recurred. The remainder were not benefited. In those patients in whom the drug was successful, the time required for relief was fairly constant. Fifty milligrams of cortisone was given orally as soon as the headache was clearly established. No effect was noted until two hours after ingestion, when the headache rather suddenly disappeared. In one patient who was observed closely, three severe headaches were completely relieved after exactly the same time interval of two hours after ingestion.

Many patients who had been diagnosed as having migraine were not relieved by cortisone. Many of these, on closer scrutiny, with more rigid criteria, probably have tension headaches. All the patients in whom the cortisone was successful had migraine by the most rigid criteria. No case of tension headache was relieved.

Two patients with histamine headaches were treated with cortisone. Each patient had his headache exactly one hour after going to sleep. Fifty milligrams of cortisone orally one hour before retiring abolished the expected headache. In each of these two patients no headache was ever experienced after the cortisone although recurrences were frequent after it was discontinued.

The patients with histamine headaches were instructed to take the drug for three to five nights, then discontinue it. The patients with migraine did not take the drug as a prophylaxis but only after the headache was well established.

Although this series is small, the dramatic relief experienced by almost 50 per cent of migraine sufferers seemed to warrant this preliminary report and should stimulate evaluation in an adequate number of patients.

*From the Department of Internal Medicine, Great Falls Clinic, Great Falls, Montana.

Various factors during pregnancy (intestinal displacement, atony, inactivity) make it virtually impossible for most women to go through the gestation period without constipation.

# CONSTIPATION IN PREGNANCY:

## *Satisfactorily controlled with Metamucil®*

Metamucil, with its physiologic principles of "smoothage" and "normohydration," is well tolerated for pregnancy constipation. This bland vegetable colloid may be used throughout the entire nine-month period without fear of forming a "habit" and without irritation to the mucosa.

Greenhill[1] suggests that Metamucil be given every other night. He also recommends that Metamucil be given in conjunction with a proper diet, during the lying-in period of the puerperium.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Greenhill, J. P.: Principles and Practice of Obstetrics, ed. 10, Philadelphia, W. B. Saunders Company, 1951, pp. 103-104; 311; 332.

*SEARLE Research in the Service of Medicine*

# Organization



## COLORADO
## State Medical Society

### *The President-Elect*

Samuel P. Newman, M.D., of Denver, was chosen President-Elect of the Colorado State Medical Society by the House of Delegates at the 83rd Annual Session in Denver. He will serve as President during the 1954-55 year when he will succeed Dr. Claude D. Bonham.

SAMUEL P. NEWMAN

The President-Elect entered the private practice of medicine in Denver in July, 1933, and is an orthopedic surgeon. During World War II he served with the U. S. Navy from October, 1942, to January, 1946, leaving the service with the rank of Lieutenant Commander. His overseas medical duty was with the First Marine Airwing in the South Pacific.

Dr. Newman was a member of the Public Policy Committee of the State Society for the period 1937-42 and for two years served as chairman. He was a member and chairman again for 1946-47. He was a member of the Society's Board of Trustees for four years, serving as its chairman twice. He was Vice President of the Society for the 1949-50 year. He has also been active in the Denver Medical Society, serving on its Public Policy and Program Committees, and was Vice President in 1947. He has served one year of an unexpired term and one of a five-year term on the Council on Scientific Assembly of the American Medical Association.

Since 1947 he has been assistant clinical professor of orthopedic surgery at the University of Colorado School of Medicine.

He is a Fellow of the American College of Surgeons and of the International College of Surgeons, and is a member of the Southwestern Surgical Congress. He is a member of the Board of Trustees of Colorado Hospital Service and of the Executive Committee of that organization.

He was born in Ratcliff, Texas, July 27, 1907, and graduated from high school at Lufkin, Texas. He received his M.D. from the University of Texas in 1932 and interned at St. Luke's Hospital, Denver. Dr. and Mrs. Newman and their three children live in Lakewood.

### *Highlights of The Annual Session*

It was the second largest annual session in the history of the Colorado State Medical Society, September 29 to October 2, with a total registration of 1,209, including 922 Doctors of Medicine. The largest meeting in the Society's history was in 1949, when Color Television was first seen in the West and attracted hordes of physicians and laymen for this innovation in medical teaching.

Dr. Samuel P. Newman of Denver was chosen President-elect of the Society, and will succeed President Claude D. Bonham of Boulder next September. Dr. Bonham was installed the last day of the session this year, succeeding Dr. William A. Liggett of Denver.

Dr. Frank I. Nicks of Colorado Springs was elected Treasurer for a three-year term, succeeding Dr. William A. Campbell, also of Colorado Springs. Dr. C. Walter Metz of Denver was elected to a three-year term on the Board of Trustees, succeeding Dr. McKinnie L. Phelps of Denver. Dr. Lawrence D. Buchanan of Wray was elected Vice President for the current year.

The House also chose the following additional officers:

Speaker of the House of Delegates, Dr. Eugene B. Ley, Pueblo.

Vice-Speaker of the House, Dr. John A. Weaver, Jr., Greeley.

Foundation Advocate, Dr. Walter W. King, Denver.

Delegate to the A.M.A., Dr. George A. Unfug, Pueblo.

Alternate Delegate to the A.M.A., Dr. E. H. Munro, Grand Junction.

Board of Supervisors, two-year terms: Drs. David W. McCarty, Longmont; Duane F. Hartshorn, Fort Collins; Geno Saccomanno, Grand Junction; Kenneth H. Beebe, Sterling; Albert P. Ley, Monte Vista; William N. Baker, Pueblo.

Board of Councilors, three-year terms: District 4, Dr. Ward C. Fenton, Rocky Ford; District 5, Dr. Scott A. Gale, Pueblo; District 6, Dr. Herman W. Roth, Monte Vista.

The House chose Estes Park for the 86th Annual Session in 1956, provided the Trustees find that adequate facilities are available, and if such is not the case, it will be held in Colorado Springs. The 1954 meeting will be in Colorado Springs and the 1955 session in Denver.

The House of Delegates held four meetings during the Annual Session and, working largely through its seven Reference Committees, conducted a tremendous amount of business. Among the principal actions taken were these:

1. Supported a request from the Denver Police Department and the Highway Patrol that manufacturers be urged to install safety belts in all passenger cars.

2. Adopted two constitutional amendments proposed a year ago, one limiting the voting privilege of the presiding officer to that of breaking a tie; the other clarifying classification of So-

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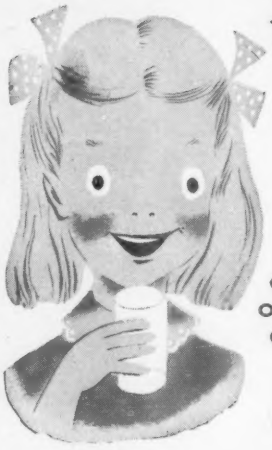

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ciety members, giving permanent recognition to the emeritus members.

3. Rejected an amendment to increase the Board of Trustees from nine to eleven members by adding the two immediate Past Presidents as regular voting members. They will continue as ex-officio non-voting members.

4. Approved three Certificates of Service, reported later in this article.

5. Elected to Honorary Membership in the Society Dr. Harry Austin Smith, Whittier, California, President of the Colorado Medical Society for 1921-22.

6. Adopted a clarifying revision of the Society's By-Laws, designed to streamline and coordinate the Society's committee organization and to simplify reference to many sections and sub-sections of this long document.

7. Voted support of the A.M.A. stand with reference to VA care for veterans with non-service connected disabilities.

8. Passed the osteopathic matter back to the A.M.A. by adopting a Reference Committee report that the key to any change in relationship hinges upon determination by the A.M.A.'s Judicial Council as to wether or not it is "cultism."

9. Adopted an amendment to the By-Laws previously proposed by the Board of Councilors whereby a physician expelled from membership in this Society may not be re-elected to membership by any component society without further advice from the Board of Councilors.

10. Adopted a Reference Committee report, delivered after extensive hearings on a supplemental report of the Board of Trustees, relating to the Board and the Executive Office, which refers the matter back to the Trustees for further study by a new committee.

As authorized by a Standing Rule of the House of Delegates, the Board of Trustees had offered nominations for Certificates of Service. In some years the Board has made no such nominations, but three were proposed this year, and the House of Delegates unanimously confirmed all three. The certificates were presented at a ceremony on the last afternoon of the Session, by the retiring President, Dr. Liggett.

The first certificate was awarded to Dr. Edgar A. Elliff of Sterling, inscribed "Medical Servant of Good Government" and commended his example to other physicians and his personal sacrifices through service in the Senate of the Colorado General Assembly.

Another certificate was awarded to Dr. George W. Stiles, "Public Health Leader for More Than Forty Years," in recognition of his laboratory research over the years concerning animal diseases transmissible to man. Dr. Stiles has recently retired.

A third certificate went to Mr. Robert L. Perkin, as "Science Writer of Fine Competence and High Integrity," for his contribution to public health through his reporting of health and medical news and his writing of health articles. Mr. Perkin is a member of the staff of The Rocky Mountain News in Denver.

Dr. Liggett himself, as retiring President, was awarded a Certificate of Service and a medallion commemorative of his presidency, as one of the first acts of Dr. Bonham's presidency.

Upon adjournment of the Annual Session, the Board of Trustees, including its newly elected members, reorganized for the year and elected Dr. Irvin E. Hendryson, whose term as Constitutional Secretary has another year to run, as Chairman of the Board for this year. The Board selected Drs. Hendryson, Metz, William R. Lipscomb, Newman, Bonham and Robert T. Porter as its Executive Committee for this year.

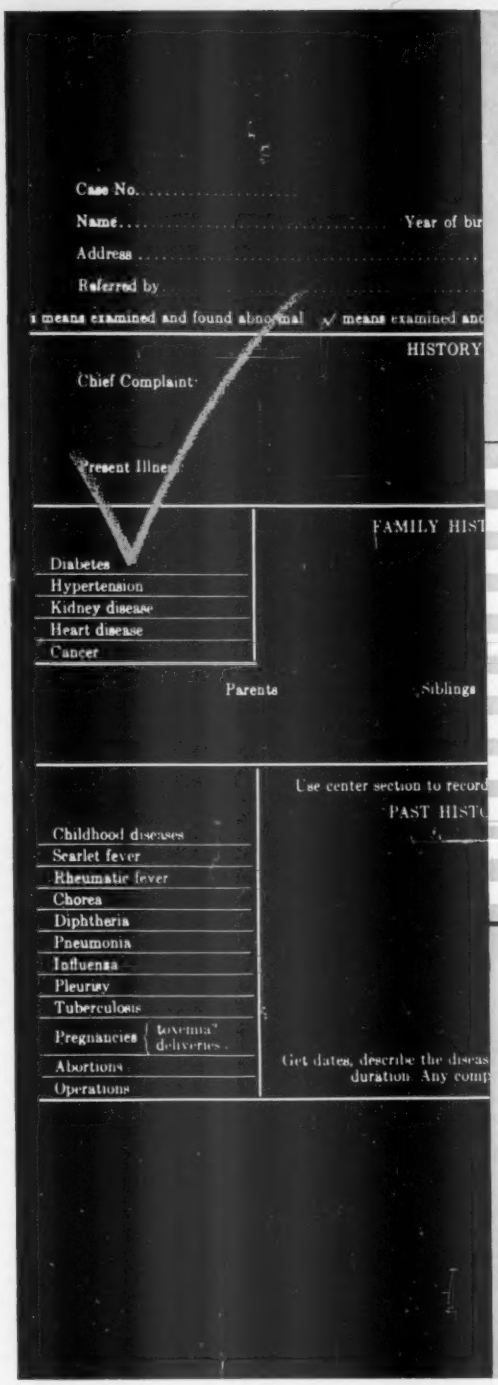
The Board of Councilors also reorganized for the year, re-electing Dr. Leo W. Lloyd of Durango as Chairman and Dr. Herman W. Roth of Monte Vista as Vice Chairman.

The week also marked a busy session for the Woman's Auxiliary. The Auxiliary also handled arrangements for the banquet and dance in the usual capable manner. Two luncheons were held and the guest speakers were Congressman Edgar Chenoweth of Trinidad, and Mrs. Mason Lawson, Litlle Rock, Arkansas, Treasurer of the Auxiliary to the A.M.A. These Auxiliary officers were chosen: President, Mrs. H. H. Ziegel, Collbran; President-Elect, Mrs. John B. Grow, Denver; First Vice President, Mrs. Robert T. Porter, Greeley; Second Vice President, Mrs. William C. Shontz, Pueblo; Third Vice President, Mrs. V. E. Wolhauer, Brush; Fourth Vice President, Mrs. John Simon, Jr., Englewood; Treasurer, Mrs. Clark Hepp, Denver; Recording Secretary, Mrs. Harry D. Jones, Longmont; Corresponding Secretary, Mrs. Edward J. Meister, Denver; Parliamentarian, Mrs. James W. Lewis, Colorado Springs; Custodian of Files, Mrs. George F. Wollgast, Denver; Historian, Mrs. E. R. Phillips, Delta; Auditor, Mrs. S. P. Esposito, Aurora.

**Retiring President William A. Liggett presents the Colorado Medical Society's Certificates of Service to the 1953 award winners. Left to right: Dr. Liggett, Dr. George W. Stiles, Dr. Edgar A. Elliff and Mr. Robert L. Perkin.**

The banquet speaker was Mr. Palmer Hoyt, editor and publisher of The Denver Post, who said that while the socialized medicine issue is dead at the moment, it can be revived at any time. He urged physicians to emphasize better public-patient relations and stronger community service as an antidote against future threats from those who would socialize medicine.

Other social highlights of the week included the annual stag dinner and entertainment, which this year was given to the Society by Mr. Julius Berbert in commemoration of his fiftieth anniversary of founding the Berbert Surgical Supply Company, and a special testimonial dinner given by the Board of Councilors and former members of that Board for Dr. Ella A. Mead, who has served continuously as a Councilor since October 1, 1925.




when the history hints at diabetes

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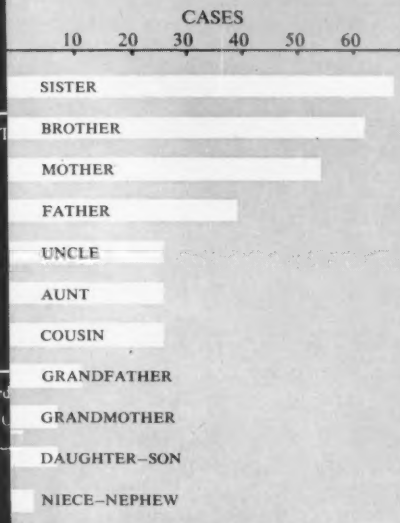


**The Diabetic Relatives of 265 Diabetics**[1]

In view of "...the very high incidence of...unsuspected cases among the blood relatives of diabetic patients,"[2] urine-sugar testing of all such individuals should be routine and frequent.

1. Barach, J. H.: Diabetes and Its Treatment, New York, Oxford University Press, 1949, p. 38.
2. Allen, F. M.: Diabetes Mellitus, in Piersol, G. M., and Bortz, E. L.: Cyclopedia of Medicine, Surgery, Specialties, Philadelphia, F. A. Davis Company, 1951, vol. 4, p. 505.

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# UTAH
## State Medical Association

### MINUTES OF THE MEETING OF THE HOUSE OF DELEGATES

### of the

### UTAH STATE MEDICAL ASSOCIATION

**Salt Lake City — September 9, 1953**

The Fifty-Ninth Annual Meeting of the House of Delegates of the Utah State Medical Association was called to order at 9:00 a.m. by President K. B. Castleton.

The following Delegates or Alternates were present upon the reading of the Roll Call by Dr. John H. Carlquist, Chairman of the Credentials Committee, or appeared during the course of the session:

Ex-Officio Members: K. B. Castleton, F. K. Bartlett, J. R. Miller, V. L. Rees, J. E. Dorman, George M. Fister.
Cache Valley: R. S. Budge, C. C. Randall.
Carbon County: James K. McClintock, Jr., Gail W. Haut.
Central Utah: H. Asa Dewey, R. N. Malouf.
Salt Lake County: elected in 1951: A. W. Middleton, John Z. Bowers, Wallace Brooke, George H. Curtis, John H. Carlquist, Bascom Palmer, Charles Ruggeri, Leslie B. White, James F. Orme, Burke M. Snow, Lewis W. Kirkman, Eliot Snow, Wm. H. Bennion, Ray T. Woolsey, Paul S. Richards, James F. Bosma. Elected in 1952: Wm. Ray Rumel, H. R. Reichman, W. E. Peltzer, R. P. Middleton, John Z. Brown, Jr., Dean Spear, Robert Snow, W. J. Morginson, F. F. Hatch, Scott M. Smith, Donald E. Smith, Garner B. Meads, R. D. Beech, Paul D. Keller, Elvon G. Jackson, John H. Clark, Jay Henderson, Paul Clayton, Alan P. MacFarlane, Philip B. Price, Wm. R. Young, E. B. Muir, A. C. Callister, Warren R. Tepper.
Southern Utah: L. W. Sorenson.
Uintah Basin: T. R. Seager.
Utah County: Boyd J. Larsen, Riley G. Clark, John M. Bowen, D. V. Poppen, J. H. Quinn, H. D. Rees, G. Y. Anderson, G. A. Richards, G. L. Allen.
Weber County: Drew M. Petersen, L. P. Matthei, A. J. Lund, S. L. Moskowitz, J. H. Rasmussen, W. P. Daines, A. A. Imus, Vernal Johnson.

The minutes of the 1952 meeting, as published in the Rocky Mountain Medical Journal, were approved as published.

The Committee on Credentials reported a quorum present.

The next item of business was the annual address of the President, Dr. Kenneth B. Castleton.*

The next item of business was the Report of the Delegate to the A.M.A., as published.

Dr. Burke M. Snow and others discussed at length the action of the A.M.A. last June in opposing the care of veterans for non-service connected disability. The Utah State Association had already sent telegrams to all the Utah congressional delegation asking that they support this view.

Mr. Bowman reported on a special A.M.A. meeting on the veterans' program, stating the A.M.A. plans distinct action in the near future to follow up the resolution that was passed at the last House of Delegates.

Dr. George M. Fister: The suggestion that the House of Delegates here go on record as endorsing the action taken by the A.M.A. in this matter is fine. After all, the pressure has to be put on now to change the congressional law in order to put through what we all favor.

Dr. A. C. Callister: If you will consider that as a motion, I will second it.

Dr. Fister's motion carried unanimously.

President Castleton: We will send a telegram to the headquarters of the A.M.A. and advise them of the action of the House. The next item on the agenda is the report of the Secretary, Dr. Homer Smith. This, too, was published in your pamphlet. I will entertain a motion to accept the Report of the Secretary.

Dr. Scott Smith's motion to accept the report was carried unanimously.

The next item of business was the Report of the Treasurer.

Dr. J. R. Miller: Since a discussion of the budget requires a knowledge of the financial situation, the committee felt that the Treasurer's Report and the Budget Committee Report should be given together. We will read first the Treasurer's Report.

Your published pamphlet of Committee Reports contains the condensed statement from the audit of the Association's business for the fiscal year ended July 31, 1953. The cash balance of $15,326.99 as of August 1, 1953, should be adequate to carry the projected expenses of the Association until the dues for the next year are received. There is a cushion in the form of profit from the Bulletin and general fund cash reserves which are to be left intact unless there is some change in policy enacted during this session when the Budget Committee Report is considered.

The official audit by the accounting firm of Goddard, Suniville and Griffin is held in the office of the Association where it is available to inspection by any member.

Dr. Robert Snow: I move we accept the Report of the Treasurer for the year 1952-53.

Dr. Ruggeri: Second the motion.

Dr. Robert Snow's motion carried unanimously.

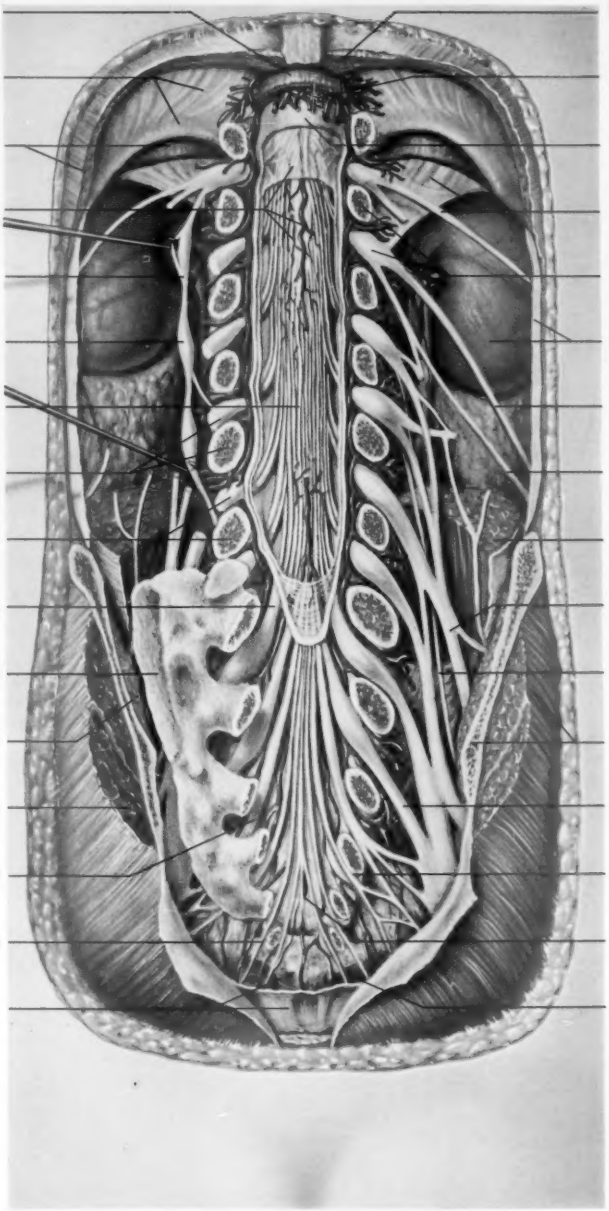
Dr. J. R. Miller: The Budget Committee consisted of four members. The committee met at the Association office August 19, 1953, prior to which meeting several interviews had occurred between the Executive Secretary and the Treasurer. To present the subject graphically the attached exhibit was prepared to serve as a guide for action by the House of Delegates. It is our opinion that in order to continue the momentum of our Association activities in the face of inflation and projected administrative costs without incurring a deficit, the dues for the calendar year 1954 should be $50.00. The present dues are $45.00.

President Castleton: I would like to mention several items that I think merit a good deal of thought on your part. One is to increase the dues $5.00. This would be necessary if we are to accept the budget as proposed. There are several items which are increased — or at least a few which are increased.

At this time I think we should also give consideration to the recommendations of the A.M.A. that we increase dues $20 per year, this $20 being earmarked for the American Medical Education Foundation. As you know, the American Medical Education Foundation has been in operation for two or three years on a purely voluntary basis, the purpose of it being to raise funds from the medical profession to aid the medical schools which, incidentally, are having more or less serious financial problems, with the hope of avoiding possible Federal subsidization. During the past couple of years these drives have been

*Separately published in the November, 1953, issue of this Journal.

# Lumbar *and* Sacral Regions *of the* Spinal Cord




*This is one of a series of paintings for Lederle by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.*

Lederle

*A wide variety of infections*
*of the spine are caused*
*by organisms susceptible to*

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HYDROCHLORIDE CRYSTALLINE

*This antibiotic is therapeutic*
*for such infections,*
*including chronic osteomyelitis*
*of the pelvis and sacrum.*
*It is also useful as a*
*prophylactic prior to surgery.*

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relatively successful. They have become increasingly so. Recently the House of Delegates of the Illinois State Society increased their dues $20 for this particular item, and it was the recommendation of the House of Delegates of the A.M.A. that all other State Societies consider a similar stand.

Dr. R. N. Malouf: Is it felt that taking the $20 from every member is going to take the place of these voluntary contributions?

President Castleton: Yes.

Dr. Malouf: Would they get as much money on a national basis as they do now on a voluntary basis?

President Castleton: Much more. Dr. Bowers, I am sure, can tell us that particularly. During the past year, what was it, a million and a half, the Foundation raised?

Dr. John Z. Bowers: Yes.

President Castleton: With $20 per person per year, it would be $4,000,000. Now there is a drive made each year. The number of contributors is not very great.

There are two or three other things we ought to consider. I personally would rather pay more dues and have a good organization doing a good job than I would to pay less dues and have an inactive organization. On the other hand, we also reach a point of diminishing returns; we don't want to get dues so high they will drive a lot of members out of the Society.

Dr. Bowers, would you explain, if the medical profession contributes $4,000,000, how much private industry might contribute, or how much they might try to get?

Dr. Bowers: Private industry is trying to get everything possible. And if you apply the curve showing the rise in their contribution, at the last meeting I attended we anticipated it would be possible to get something between four and five million dollars from private industry within the next year.

Dr. A. C. Callister: I am very much in favor of the increase of $5.00 in dues because of the projects we have before us.

Dr. Wallace Brooke: Simply for the purpose of solidifying Dr. Bowers' remarks, I think what remains in the mind of all of us as we listen to this is: What specific things would you expect to occur if the Federal Government did supervise or subsidize medical education? Have there been schools where this has occurred in one form or the other? — and specifically stating, how does the government subsidize the attainment of medical education?

Dr. John Z. Bowers: I think there are several problems that have been pointed out as representing some of the threats that would occur with increasing Federal subsidization.

First of these is the fact the medical schools would lose control of selection of students and admissions. They would be required to expand their student bodies far beyond the availability of facilities and faculties; and accordingly, the caliber of the product coming out of the medical schools would fall tremendously.

Second, that the selection of faculty, the rating of faculty and the promotion of faculty would to a considerable extent pass out of the authority and responsibility of the medical schools to Federal officers who would not be, as we know, at all times objective in their evaluation of the problems of the profession.

Third, there would be considerable dislocation in the curriculum. Three years ago when the Korean War was ballooning, the armed forces came out with a request that we insert into the medical curriculum large blocks of time devoted to teaching of what they call "military medicine," and as you know the medical curriculum is already overextended. We teach too much probably as it is. All of the courses and all of the subject material which they wanted us to include already exists in several places in our curriculum; but they would only countenance the idea that we would set up a separate educational program to teach "military medicine." I think this represents what would occur if our money was coming from Washington, and a group of men who really know very little about medical education would come out in times of national urgency — I wouldn't say "emergency" — with recommendations for unsound, unrealistic changes in the curriculum.

Dr. George M. Fister: I might state that this is merely referred back here by the A.M.A. House of Delegates, and I think personally that it should be passed because it is an equitable way to do it. Dr. Bowers stated—there were thirty-four physicians in the state who contributed $5,220—and yet the State Medical School received back from this fund $25,000; isn't that right, Dr. Bowers?

Dr. Bowers: Yes, it is.

Dr. Fister: So while we are sending this back into a central fund, we are receiving back from that more than we contributed. There are about a hundred-forty or fifty thousand physicians in the A.M.A. If this thing were passed by each state, there could be put into this fund roughly each year, four to five million dollars for medical education.

Dr. Paul Clayton: You are forgetting one thing. We operate a business, if you want to look at it that way. And your dues in your total overhead for a year's time — office rent, salary for office assistants — your dues become a rather small item, and still those dues represent the thing that keeps you in the practice of medicine today. Include this $20 as an expense and it is the best investment that we can make to maintain the type of medical practice that we have today. If you want to look at it with the rest of your overhead, it doesn't amount to 5 per cent of it.

Dr. Philip B. Price: Mr. Chairman, I would like to speak to Dr. Brooke's question. I happened to live in a foreign country for a number of years where at that time the government control of medical education came into effect, and I was in a medical school. Two effects were immediately noticed and I think they are very important for us to consider.

The first was that medical education in the country became standardized. All medical schools had to be exactly the same. And I am sure that might occur because you only have to look at the Government's hospitals over the country to see how fond the Government is of standardization. It meant some schools were levelled down to the general average.

The second effect that came in very promptly was that the Government required all the graduates of the school to give the Government a certain amount of service after they finished. I can very readily believe that might occur over here, and I would hate to see that happen.

Dr. V. L. Rees: I am very much in favor of this increase of the dues for this purpose and I would like to put it in the form of a motion:

That our state dues be increased $20 per year, the funds collected from this increase to be paid to the Educational Fund of the A.M.A. — and then a proviso be placed there — that in case of hardship, whether it be young doctors in prac-

tice, whether it be the doctor partially retired, or whether it be the doctor who is on a full-time salary basis, at the discretion of the Medical Council his dues be reduced in those cases, otherwise it would apply to all concerned.

Dr. Woolsey: Second the motion.

Dr. Drew M. Petersen: Does that include the $5.00 suggested by the Budget Committee?

President Castleton: No.

Thereupon a vote was taken and the motion carried unanimously.

President Castleton: I would suggest that you men who are delegates from the various societies explain this matter to your members.

Dr. Bascom Palmer: I hope that this action of the House of Delegates won't be interpreted by those who can afford to pay more as releasing them from the obligation to contribute more.

President Castleton: That is true. If they can contribute additional funds, they should.

The next item is the Utah Health Council. I presume you know what that is; the organization consists of doctors, dentists, druggists, etc. Dr. Dean Spear is chairman of that committee.

Dr. Paul Clayton: I think most of you are familiar with the programs. There are nine weekly radio programs and two weekly television programs. We have already had requests from a new television station going into operation to place a program on that station.

While I am talking I will answer a criticism we received that we are too extended, that they aren't the best programs and so forth. I might point out, by cutting the programs in half, we wouldn't cut the budget in half. The only item we would cut would be the recording materials, which in a year's time runs approximately a thousand dollars. So, cutting the programs in half, you would cut very little off the budget. And the fact that every radio and television station gives us time speaks for its effect on the general public. They want us on the air, which means that the public is requesting it. Otherwise they wouldn't want to give us time to put the program on.

President Castleton: There is no question in my mind but that the Utah Health Council has done a tremendous job. The only question is: How much can we afford to give?

Dr. J. R. Miller: My comment is that this project is like the American Medical Education Foundation; everybody benefits from it; therefore, the load should be distributed.

Dr. Burke M. Snow: It is necessary that the Utah Health Council be assured of a certain budget, and they can't get it on a basis of voluntary contributions. We should probably guarantee them a certain amount from our Association.

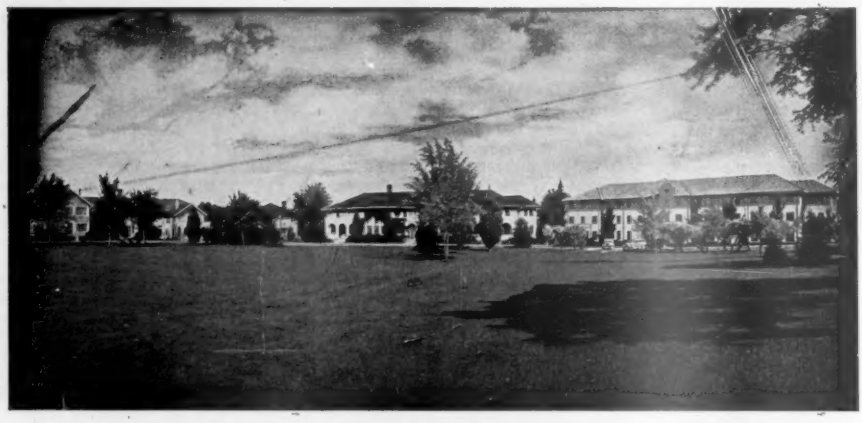
President Castleton: There has been some criticism of the program. One is on the basis it is over-extended, too many programs, fewer would be better. One is that there isn't enough medical supervision of the program. Whether those criticisms are justified I don't know. Those are some that have come to my ears.

Dr. F. F. Hatch: I move we proceed with the items of the budget, unless there is feeling to the contrary and get to the bottom of it and give the Budget Committee a vote of confidence if we agree.

Dr. Paul Clayton: I would like to make a motion that we increase the dues $5.00 for the next year so the budget will be balanced.

Dr. John Z. Brown: Second the motion.

President Castleton: The motion passes.

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**C. F. Rice, Superintendent, Colorado Springs, Colorado**

# How the greater efficiency of Kent's Micronite Filter is verified

**Until the new** KENT cigarette was introduced last year, factual evidence of the comparative efficiency of filter-tip cigarettes did not exist.

Realizing this, the makers of KENT decided to compare the efficiency of its exclusive Micronite Filter with other filters—and to release the findings to the general public.

On delicate analytical balances, the *weight* of the nicotine and tars left in smoke after passing through the Micronite Filter was compared with the *weight* of the irritants left in the smoke after passing through conventional filters.

These scientific comparison tests show that while conventional filters remove some irritants, KENT's Micronite Filter *approaches 7 times the efficiency of other filters in the removal of nicotine and tars* and is virtually twice as effective as the next most efficient cigarette filter.

In addition, tests have been made on physiological reactions to cigarette smoke—and the findings have been released to the medical profession only.

These tests, without exception, show that KENT's Micronite Filter is the first to remove enough of the irritants from cigarette smoke to give susceptible smokers (about 1 out of every 3) the protection they need. At the same time, this filter lets through all the rich taste of fine tobaccos that gives smokers the satisfaction they want.

Already the new KENT has become so popular that it outsells brands on the market for years. If you have yet to try the new KENT, may we suggest you do so soon?


"KENT" AND "MICRONITE" ARE REGISTERED TRADEMARKS OF P. LORILLARD COMPANY

*Advertisement*

From where I sit *by* Joe Marsh

## Modern Art Takes a Licking!

Did you know we had a real artist in town? Yes sir! Handy Jackson was a contributor to the Sculpture Exhibition at the Fair last week.

*His work was streaky pink and curved all around—sort of streamlined. Caused quite a stir. Nobody was sure what it was supposed to be, but some liked it and thought it was good art. Handy gave me the lowdown:*

"Why, it was nothing but a piece of cattle salt our cows have been lickin' at for months. I just had it mounted. Fooled a lot of folks—one fellow even wanted to buy it!"

*From where I sit, Handy's "modern art" just shows how some people can be led astray. Some even get to be "experts"—especially about the other fellow's business. They're quick to tell a man how to practice his profession . . . or even to interfere with his preference for a temperate glass of beer. Let's live and let live—not set ourselves up as the "model" for the other fellow.*

Joe Marsh

*Copyright, 1953, United States Brewers Foundation*

Dr. E. B. Muir: I would like to move a vote of appreciation to the outgoing President.

President Castleton: Is that necessary? Thank you. Let's have the Report of the Councilor of the First District. It is printed in your booklet.

Dr. L. P. Matthei: I make a motion the Report of the Councilor of the First District be accepted.

Dr. Dean Spear: Second the motion.

Dr. Matthei's motion carried unanimously.

The Report of the Councilor of the Second District.

Dr. Eliot Snow: I move we accept it.

Dr. Bascom Palmer: Second the motion.

The motion carried unanimously.

Report of the Councilor of the Third District.

Dr. S. L. Moskowitz: I move it be accepted.

Dr. Burke M. Snow: Second the motion.

The motion carried unanimously.

Dr. L. P. Matthei: I would like to bring up the changes in the Constitution and By-Laws that were made last year. You all voted for them last year, but to make them official according to our Constitution and By-Laws, we have to vote on them at this time.

Dr. Lewis K. Kirkman: Second the motion.

President Castleton: The motion is that we accept the proposed changes in the Constitution and By-Laws as presented last year. As you know, the proposed changes have to go over from one session to the next, so we are in a position now to act on the proposed changes of last year. It is my understanding that the Committee on Constitution and By-Laws and the Reference Committee both recommended the adoption of these changes; is that correct?

The question was called for and the motion carried unanimously.

President Castleton: We will adjourn until 1:00 o'clock.

---

The House of Delegates reconvened at 1:00 o'clock.

President Castleton: We are particularly pleased to have Harvey Sethman here this afternoon. He is well known to all of you. He is Secretary of the Colorado Society, and I want to thank him before this group for the many favors he has rendered to this Association and to me personally; he has been a great help to us. We would like to have him say a few words to us.

Mr. Harvey Sethman: Thank you, Doctor. Gentlemen, more important people than I will bring you official greetings from the Colorado Society this week. I have the advantage over our President and the other doctors by being here first. I came over primarily to be of assistance to Harold and your committee in setting up things for the Rocky Mountain Medical Conference the rest of this week. We have our budget problems in Colorado, like I heard you discussing this morning — they are not too different. We have some budgetary and cost problems right now in the matter of our mutual Rocky Mountain Medical Journal. Harold and others are working with me and eventually we will get it to the important people like your Council, to approve some changes that will get our Journal in a better financial situation. It hasn't been too good this year. Printing costs, paper costs and so forth, have gone up tremendously in the last few years, as I am sure you understand. But we are going to work to keep our Journal up to the high quality which I hope has been pleasing you. We are pleased to know that there has been more scientific material in the Journal from Utah this year than either of the two preceding years.

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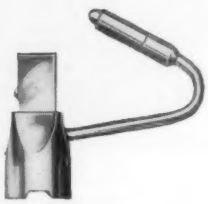

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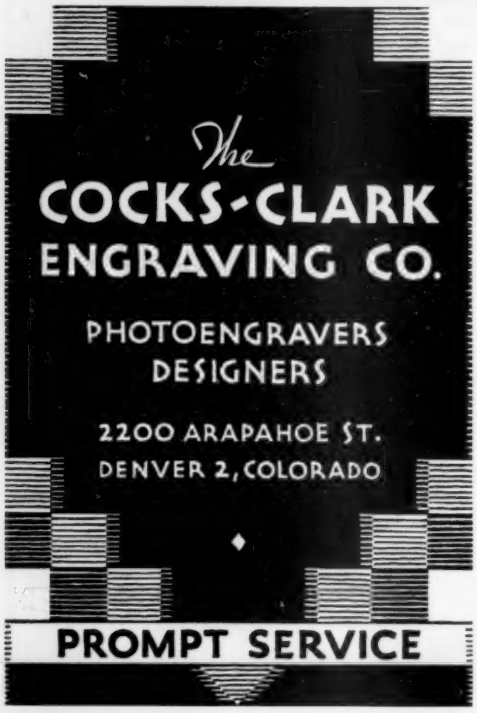


President Castleton: Thank you. The next item of business is Miscellaneous Business.

Dr. L. P. Matthei: There has been common concern among the whole profession the last several years in regard to medical education of medical students in medical economics and medical ethics. Many times I have heard men say, "Well, they should teach them more while they are in medical school." And I noted in the report of our delegate to the A.M.A. to this House of Delegates, that the A.M.A. is contributing $500,000 to medical schools for their use, and I would like to make a recommendation that we instruct our delegate at the next meeting of the A.M.A. to suggest to the A.M.A. that they announce a prize of five or ten thousand dollars to the medical school providing the best course in medical ethics in the United States, and a similar prize for the school giving the best course on medical economics, on actual operation of an office. A lot of these young fellows coming out will perhaps have a few less problems.

Dr. Ray T. Woolsey: I think if you include in that, medical jurisprudence, you are covering a good field. Certainly the work of the Board of Medical Examiners in the last few years has indicated that graduates of medical schools throughout the country have so little knowledge in regards to the question of medical jurisprudence that to my mind it is no wonder that insurance rates are going up — constantly going up — and we are constantly having so many malpractice suits filed against doctors throughout the nation.

President Castleton: Dr. Woolsey leads me to another matter I was going to bring up later, but I think we might bring it up at this time, namely, the insurance rates for malpractice. As you know, the trend has been definitely upward. We have had some enormous increases in recent years. Some major companies will no longer write malpractice insurance. Some have withdrawn from certain areas. During the past week, one of the local insurance men approached me and told me that he has a plan whereby he thinks that the members of the State Society could save a considerable amount of money provided they were willing to go into the thing on a more or less unanimous basis. I don't have the details to bring before you. I don't know enough about the company to know whether it is a good one or not, but I think it is something that perhaps we should think about.

Dr. F. K. Bartlett: If you are going to meet with any one agent, wouldn't it be well to contact as many of the leading insurance agents as write medical insurance and have them each submit a bid? That would avoid any partisanship.

Dr. Ray. T. Woolsey: I move that the President appoint a statewide committee to investigate this question of malpractice insurance and make such recommendations as are indicated after their investigation, if necessary even to the point of calling a special meeting of the House of Delegates in order to present that to them.

President Castleton: I will accept Dr. Woolsey's motion that a committee be appointed — we will leave it to the President and Council as to who does it, will that be acceptable? — to investigate the whole matter of malpractice insurance and report to the Council or a special session of the House of Delegates if necessary.

Dr. John Z. Brown: Second the motion.

The motion carried unanimously.

Dr. L. P. Matthei: I move that our delegate to the A.M.A. be instructed to recommend to the House of Delegates of the A.M.A. that a yearly

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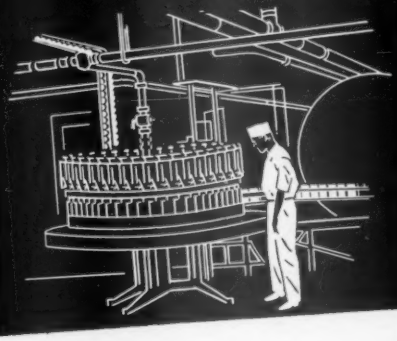

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prize of a substantial sum of money be offered to the medical schools providing the best course in: 1, Medical Ethics; 2, Medical Jurisprudence; and, 3, Medical Economics.

Dr. Woolsey: Second the motion.

President Castleton: Last winter the Utah State Medical Association requested the A.M.A. to investigate the medical care problem in Carbon County, with particular reference to Dragerton, and come up with some kind of a report which might help us in guiding our activities and attitudes in the future. Last spring a committee consisting of Dr. Arestad, Dr. Sawyer, and Dr. Carl Petersen visited the state. They spent a day in Dragerton and Price and another day in Salt Lake, and we have just received a report from them on their findings. It is rather a detailed report, with a summary.

President Castleton read the summary.

Dr. Woolsey moved that the House refer the whole matter to the UMW Committee or a special committee, at the discretion of the President or the Council.

Dr. Woolsey's motion carried unanimously.

President Castleton: We will proceed to the reports of the Reference Committees. Reference Committee No. 1, Dr. Ruggeri.

Dr. Charles Ruggeri: We have had five committee reports to discuss. The first report was the Report of the Public Relations Committee. I want to say that the full representation of Reference Committee No. 1 met and very thoroughly discussed all these reports, and the report I am making is the unanimous report of the Committee of the whole. I think in the interest of saving time, you have all read these reports, and unless you want to have them read again we will just dispense with the reading.

This report is by Dr. Peltzer and I would like to move the adoption of the report as it stands.

Dr. Matthei: Second the motion.

The motion carried unanimously.

Dr. Ruggeri: The next committee report is the Report of the Committee on Press, Radio and Television. We move the adoption of this committee report with some recommendations. There has been prepared—which has not been published in this Reports of Officers and Committees booklet—a Code of Ethics which has to do with newspapers, radio, television, and so on; and the report is not complete, as I understand it, because it is in the hands of the attorney for some corrections. The committee recommends the adoption and we so move.

Dr. Matthei: Second the motion.

President Castleton: Dr. Brooke, would you care to comment on how you arrived at this code?

Dr. Wallace Brooke: It is a long story, but what we did was acquire the "code of cooperation" of at least ten state and some county societies who had made efforts in the past to obtain a working basis between these aforementioned groups. We have incorporated sometimes their exact language, sometimes our own, on things that seemed to be relevant and good for Utah. As I mentioned in the report, I think we are particularly fortunate here regarding the people who publish our medical news.

Dr. Burke M. Snow: Second the motion.

Dr. Ruggeri's motion was carried unanimously.

Dr. Ruggeri: The next report is on Page 51,


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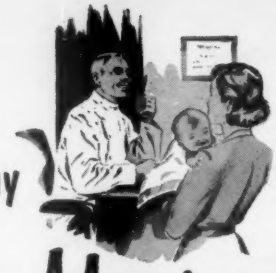

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Report of the Legislative Committee. We move that the report be adopted.

Dr. Brooke: Second the motion.

Dr. Ruggeri's motion carried unanimously.

Dr. Ruggeri: We recommend as one of the problems for the next Legislative Committee—and I think the work ought to be started immediately—that the Medical Examiners Law be restudied and any controversial features be modified, so that it would pass inspection by all groups that would be interested. I think if this is done that in the next session of the Legislature we will not have too much difficulty in having a Medical Examiners Law. So I move that that be adopted as one of the problems for the next Legislative Committee.

Dr. S. L. Moskowitz: Second the motion.

Dr. Ruggeri's motion carried unanimously.

Dr. Ruggeri: Next is the Basic Science Law. As you saw in the report, there were several reasons why we didn't consider the Basic Science Law this past year. The Legislative program which we had was so enormous and so important and so vital that we didn't have the time. That was the first reason.

The second reason was, there was quite a divergence of opinion among the members of our Association as to the need for a Basic Science Law and whether it would accomplish the purpose for which it was proposed.

So in view of those complaints and criticisms, we move that a further study of the Basic Science Law be made by the Committee and that a report be made as to their recommendation at the next House of Delegates so that we may take action at that time.

Dr. F. K. Barlett: Second the motion.

The motion carried unanimously.

Dr. Ruggeri: Now there is a resolution we would like to present for your consideration:

WHEREAS, Public Health depends to a great extent upon local initiative; and

WHEREAS, Local initiative is the responsibility of the medical profession in promoting, supervising, and maintaining the right kind of public health; and

WHEREAS, Local health participation should depend upon local financial support instead of Federal financial support:

BE IT RESOLVED, That the Utah State Medical Association endorses and encourages legislation which will encourage local financial support of needed public health activities.

Dr. Eliot Snow: Second the motion.

A vote was taken and the motion carried unanimously.

Dr. Ruggeri: We have another resolution:

WHEREAS, There is a virtual epidemic of dangerous medical practices by unqualified self-appointed medical practitioners:

BE IT RESOLVED, That the Utah State Medical Association encourages legislation which will change the punishment of practicing without proper license from that of a misdemeanor to that of a felony.

I move that resolution be adopted.

Dr. Matthei: Second the motion.

The motion carried unanimously.

Dr. Ruggeri: I would like—having had considerable experience on this Legislative Committee—to recommend that each component society of our State Association have a committee who will work among the legislators and carry out the wishes of our Association. That is in the report and we call to your attention that it can be done because time after time when we need help we don't have an organization out in the outlying parts of the state to give us the help. We are tied up. So we urge that the outlying component societies carry out that part of the recommendations in the report. The next committee report we have is the Report of the Committee on the Utah Health Council. First, we want to recommend that this report be adopted. We think this is a valuable part of the program of the State Association and we feel it is doing some good. So we recommend the adoption of the report.

Dr. Sorenson: Second the motion.

Dr. Ruggeri's motion carried unanimously.

Dr. Ruggeri: We have a resolution to present:

WHEREAS, The Speakers Bureau, sponsored by the Committee on the Utah Health Council, has carried forward a program of providing speakers for both professional and lay audiences; and

WHEREAS, This program has developed into one of the most effective public relations media sponsored by the Utah State Medical Association:

NOW, THEREFORE; BE IT RESOLVED, That the Chairman of this Committee, Dr. Dean Spear, be commended for his excellent leadership; and

BE IT FURTHER RESOLVED, That the program be broadened by sending announcements to secretaries of civic clubs throughout the state advising them of the availablity of speakers; and

BE IT FURTHER RESOLVED, That all new members of the Component County Societies be invited to become a part of this Speakers Panel and that all talks before lay groups be cleared through this Committee."

We move the adoption of this resolution.

Dr. Brooke: Second the motion.

Dr. Ruggeri's motion carried unanimously.

Dr. Ruggeri: We have a couple of remarks and recommendations to make about the television and radio programs. The programs have now been given for a little over a year and your Reference Committee feels that while they are doing a lot of good, there are some criticisms of

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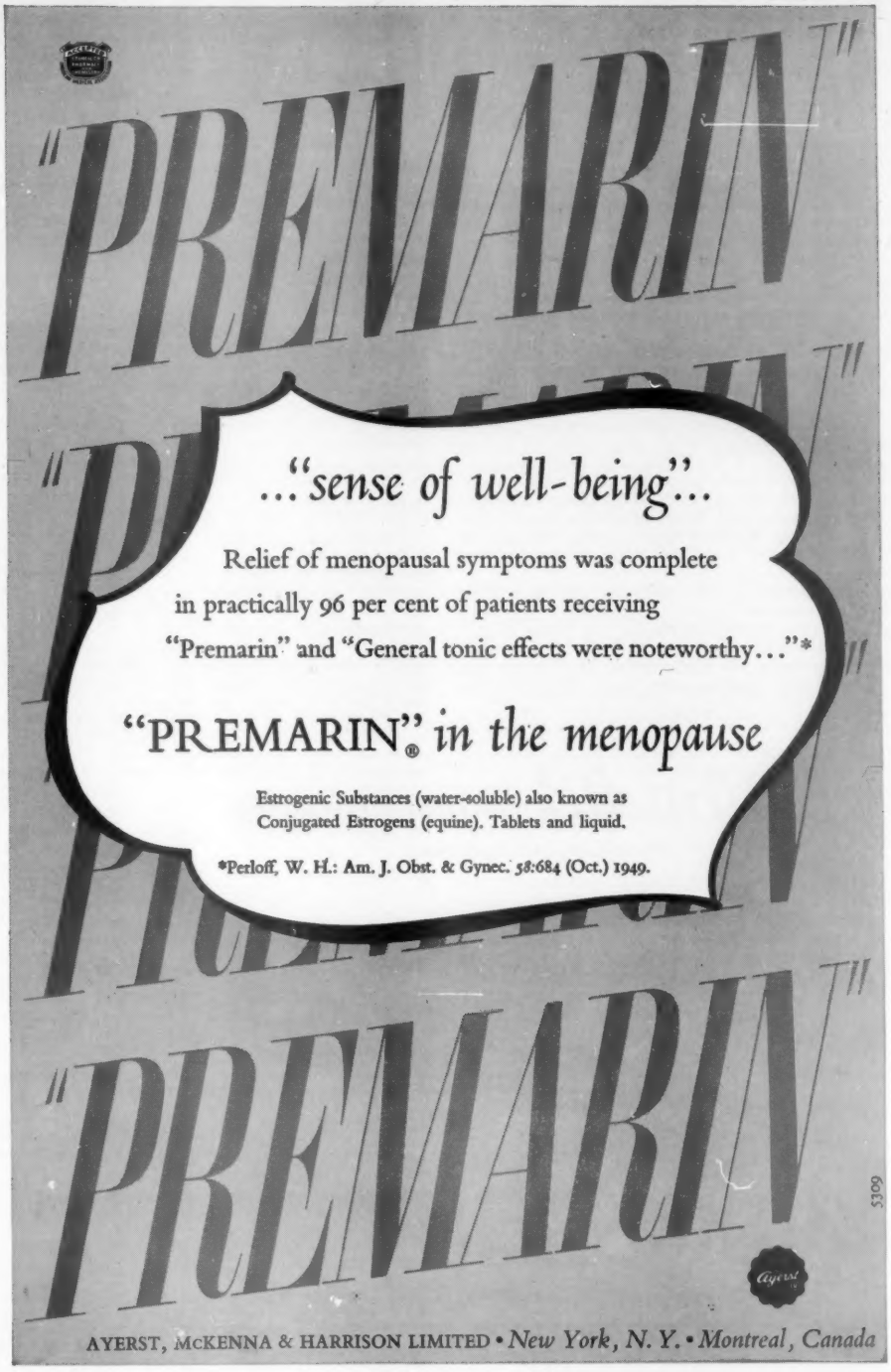
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some of the programs. You heard some of them in the morning session so I won't repeat those. But the Committee feels it is time, after about fifteen months, that the makeup of the programs be re-evaluated by the Committee in a way to see if the programs might be made a little more objective and to try and see if we can derive a little bit more or better public relations through the programs for our Medical Association. That is a recommendation. I don't know if you want it in a motion or not.

The final report of your Reference Committee No. 1 is the Report of the Newspaper Column Committee. This is a new venture this year, and the Reference Committee thinks it is a wonderful program and feels that it is doing an outstanding service. We feel that we are going to derive a considerable amount of good among the people of our State and we move the adoption of the report.

Dr. Drew M. Petersen: Second the motion.

Dr. Ruggeri's motion carried unanimously.

Dr. Drew M. Petersen: There is one other thing, Dr. Ruggeri, when we discussed this business on the newspaper article, "Your Doctor Says," a lot of people don't stop to think of the difference — and I think there is a difference— between us and an osteopath and a naturopath. So we might try to get an M.D. in there so people would know who it is; otherwise they don't know who is writing it, they don't know the others aren't members of the Utah State Medical Association.

Mr. Bowman: In the articles called, "Your Doctor," wherever doctor is mentioned we have tried to put in "your M.D. doctor" or "your M.D."; and I think maybe we can handle it that way or talk it over with the Committee. Maybe we can get M.D. in the heading some way. But we have been cognizant of that and appreciate your comment.

Dr. Ruggeri: I move that we accept the report of Reference Committee No. 1 as a whole.

Dr. John Z. Brown: Second the motion.

Dr. Ruggeri's motion carried unanimously.

President Castleton: We will proceed to the next Reference Committee, Dr. Matthei, Chairman.

Dr. Matthei: As usual, for some reason or other Reference Committees cannot always entirely agree with the reports made by the original committees. And while the work that has been done by the Committee on Constitution and By-Laws is certainly excellent, there are a few smaller points that we feel should be brought to your attention, and I am afraid we are going to have to go through item by item to get your pleasure.

In the first place, no comment was made in regard to Article IX, Section 1, Page 20. Since the vote of this morning making a Councilor from each County Society rather than three Councilors representing various districts of the state, it will be necessary to recommend that the last two words of Section 1 of Article IX be deleted and the words, "The Council," be substituted. I move that this change in the Constitution be made.

Dr. Hatch: Second the motion.

Dr. Matthei's motion carried unanimously.

Dr. Matthei: Now going back to the recommendations of the Committee on Constitution and By-Laws, the first item that they mention is Article IX, Section 3, and they ask a change in that article.

The A.M.A. has recommended for purposes of better understanding and unanimity throughout the country, rather than Board of Supervisors or


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Board of Mediation, that the term, Professional Relations Committee, be used. It is therefore with the hope of a better understanding throughout the country when the medical men get together that we submit that rather than Board of Mediation, the term, Professional Relations Committee, be adopted. We move that be done.

Dr. Leslie B. White: Second the motion.

Dr. Matthei's motion carried unanimously.

Dr. Matthei: There was some difference of opinion between the Reference Committee and the Constitution and By-Laws Committee as to their further recommendations in this same first recommendation. In talking to the Council and the President of the Society and the incoming President, the Reference Committee found that they felt that two members from each County Society for this Professional Relations Committee would be rather excessive.

I would like to put in the form of a motion, that we elect one from each of the County Medical Societies, four being elected for a period of one year from four of the Societies, and four being elected for a period of two years, and then after that, each year four men will be elected to replace the four that will be retiring.

President Castleton: In talking to the members of this Board, there is no question but what the five we now have is an inadequate number. The question then is to the effect that the Board of Supervisors, or the Professional Relations Committee, be increased to eight. The motion also included the method of staggering the election.

Dr. Matthei's motion carried unanimously.

Dr. Matthei: It is the opinion of the Reference Committee No. 2 that the Report of the Fee Schedule Committee should be accepted. However, we must comment that this does not imply that we recommend the fee schedule should be accepted because we have had no oportunity to study it. And we do feel that after you vote on the acceptance of the recommendations of the Fee Schedule Committee, that then the Chairman of the Fee Schedule Committee be given an opportunity to talk to us about their work in the past year and listen to any recommendations he might have to make.

I move we accept the Report of the Fee Schedule Committee.

Dr. Leslie B. White: Second the motion.

Dr. Matthei's motion carried unanimously.

Dr. Matthei: I would like to move that the report of Reference Committe No. 2 be accepted as a whole.

Dr. Hatch: Second the motion.

Dr. Matthei's motion carried unanimously.

Dr. Rumel: I am sorry that we did not have time enough to get this fee schedule printed up so that it could be available before this meeting, but the task of working this thing out was a tremendous one. There are between two and three thousand items on the thing. I can assure you that the fifty-three members which comprised the committee and which were representative of all the different fields of medicine and surgery, and as far as practical were geographically appointed—I can assure you that we did our level best to get the thing worked out as best we could with the basic concepts in mind that were printed in this report. With that background, I will read a resolution:

WHEREAS, A large committee of fifty-three members of the Utah State Medical Association, including physicians and surgeons practicing in all branches of medicine and surgery, have spent a great deal of time and effort in establishing an all-inclusive average fee schedule based on the basic fundamental considerations enumerated in the Report of the Fee Schedule Committee as published in the Reports of Officers and Committees for the year 1952 to 1953, 59th Annual Meeting of the House of Delegates of the Utah State Medical Association; and

WHEREAS, This report, including the basic concepts upon which the fee schedule was developed, has been approved by the members of Reference Committee No. 2; and

WHEREAS, Said fee schedule has been accepted and approved by the official Fee Schedule Committee of the State Association;

THEREFORE, BE IT RESOLVED, That the House of Delegates adopt the fee schedule which has been worked out and approved by the present Fee Schedule Committee.

Dr. Eliot Snow: Second the motion.

Dr. Rumel's motion carried.

President Castleton: We will pass on to Reference Committee No. 3, Dr. Vernal Johnson, Chairman.

Dr. Vernal Johnson: We have eleven reports to go over but I can assure you they won't take a great deal of time.

Reference Committee No. 3 met August 31, 1953, at the Utah State Medical Association headquarters and they made the following report:

Reference Committee No. 3 recommends that the following reports be accepted by the House of Delegates, and the first is a report of the Board of Supervisors. This has already been discussed. Our Committee endorses the recommendations to enlarge the Board to have a representative from each component society, which would be an increase from five to eight and to change the name from Board of Supervisors to that of Professional Relations Committee: I move that this report be accepted as presented.

Dr. Spear: Second the motion.

Dr. Johnson's motion carried unanimously.

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Dr. Johnson: The next report is the report of the Delegate to the A.M.A. This has already been acted on also. We recommend that this be accepted by the House of Delegates and commend Dr. Fister on his able and clear presentation. I move that this report be accepted by the House of Delegates.

Dr. Beech: Second the motion.

Dr. Johnson's motion carried unanimously.

Dr. Johnson: Reference Committee No. 3 recommends that the report of the Secretary and Executive Secretary be accepted by the House of Delegates and commends them on their accomplishments during this past year. I move that this report be accepted.

Dr. Sorenson: Second the motion.

Dr. Johnson's motion carried unanimously.

Dr. Johnson: The next report is that of the Rocky Mountain Medical Conference Continuing Committee. We recommend that this report be accepted by the House of Delegates, and we are sure from all indications that it will be a splendid program as outlined. We move that this report be accepted.

Dr. Matthei: Second the motion.

Dr. Johnson's motion carried unanimously.

Dr. Johnson: Reference Committee No. 3 recommends that the Report of the Necrology Committee be accepted by the House of Delegates. I move this report be accepted.

Dr. Dewey: Second the motion.

Dr. Johnson's motion carried unanimously.

President Castleton: At this time it is customary for us to stand with bowed heads for a few seconds for our members who have passed on. (Delegates stood with bowed heads).

Dr. Johnson: Reference Committee No. 3 recommends that the Report of the Blood Bank Committee be accepted by the House of Delegates and endorses the recommendations that the profession support the Red Cross Blood Center. I move this report be accepted.

Dr. Randall: Second the motion.

Dr. Johnson's motion carried unanimously.

Dr. Johnson: Reference Committee No. 3 recommends that the Report of the Advisory Committee to the Woman's Auxiliary be accepted by the House of Delegates and commends the members of the Auxiliary on their fine cooperation and accomplishments during the past year. I move this report be accepted.

Dr. Hatch: Second the motion.

Dr. Robert Snow: I would like to amend that to the extent that a letter be transmitted to the President of the Woman's Auxiliary telling them of our sentiments at this time.

Dr. Matthei: Second the amendment.

President Castleton: We will vote on the amendment.

Dr. Robert Snow's amendment carried unanimously. Dr. Johnson's motion as amended then carried unanimously.

Dr. Johnson: Reference Committee No. 3 recommends that the report of the Civil Defense Committee be accepted by the House of Delegates and endorses the recommendation that the County Societies urge the local municipal authorities to organize at least one first aid station for each large community and one for each large hospital, with provision for storage and operation of the unit three to five miles from the center of population. We also recommend that the Committee Chairman continue in this inasmuch as he is more cognizant of these problems.

Dr. Randall: Second the motion.

Dr. Johnson's motion carried unanimously.

Dr. Johnson: Reference Committee No. 3 rec-

ommends that the Report of the American Education Foundation Committee be accepted by the House of Delegates, and further recommends that the dues be increased $20 per member and that these monies be assigned to the American Education Foundation—this, of course, has already been voted on. I move this report be accepted.

Dr. Hatch: Second the motion.

Dr. Johnson's motion carried unanimously.

Dr. Johnson: Reference Committee No. 3 recommends that the Report of the Medical Education and Hospitals Committee be accepted by the House of Delegates and endorses the recommendations concerning medical ethics and indoctrination, nursing and postgraduate education. Dr. Matthei has already made a motion concerning the institution of adequate training in medical ethics, jurisprudence and economics, and there may be some questions.

I think it would be well if we could add to this report a recommendation that some form of solicitation be introduced among our girls who are already trained as nurses, rather than to spend so much time to get the girls indoctrinated and in nurses training. I think that is one of our major problems. So few of the girls remain active in our nurses training out in the hospitals. I wonder if it wouldn't probably be a greater project if one could work on the girls already trained to get into their profession.

There was also a question as to the proper term to use in designating girls who are training as practical nurses. I note in many institutions, when these girls graduate and receive their nursing certificate and cap, some of the girls have felt that there was a little let-down. However, as I understand on most of these, they have "Technical Nurse" written on them so they could differentiate. It was suggested they be called nurse technicians; however, I think that is also an erroneous term. It is probably a matter to decide in the State as to how to designate these girls, whether to keep calling them practical nurses or registered practical nurses, or at least devise some means of differentiating those from the regular nurses. I move this report be accepted.

Dr. Ruggeri: Second the motion.

Dr. Johnson's motion carried unanimously.

Dr. Johnson: Reference Committee No. 3 recommends that the Report of the Medical Economics Committee be accepted and suggests, however, that this Committee choose as a project some project such as the Reed-Keough Bill or some other suitable form of legislation which will definitely influence the economic status of physicians. As you will read in the report, they had no specific project this year. I move this report be accepted.

Dr. Dewey: Second the motion.

Dr. Johnson's motion carried unanimously.

Dr. Johnson: I move the report of Reference Committee No. 3 be accepted.

Dr. Clayton: Second the motion.

Dr. Johnson's motion carried unanimously.

President Castleton: We will next proceed with Reference Committee No. 4. Dr. Brooke is Chairman.

Dr. Brooke: Reference Committee No. 4 dealt with the following committees:

First, the Committee on Tuberculosis and Cardio-Vascular Diseases. We recommend acceptance of this report.

A question may arise in your mind as to what is Dr. Spendlove's legislation; Dr. Curtis as Chairman of the Committee refers to it. It is a


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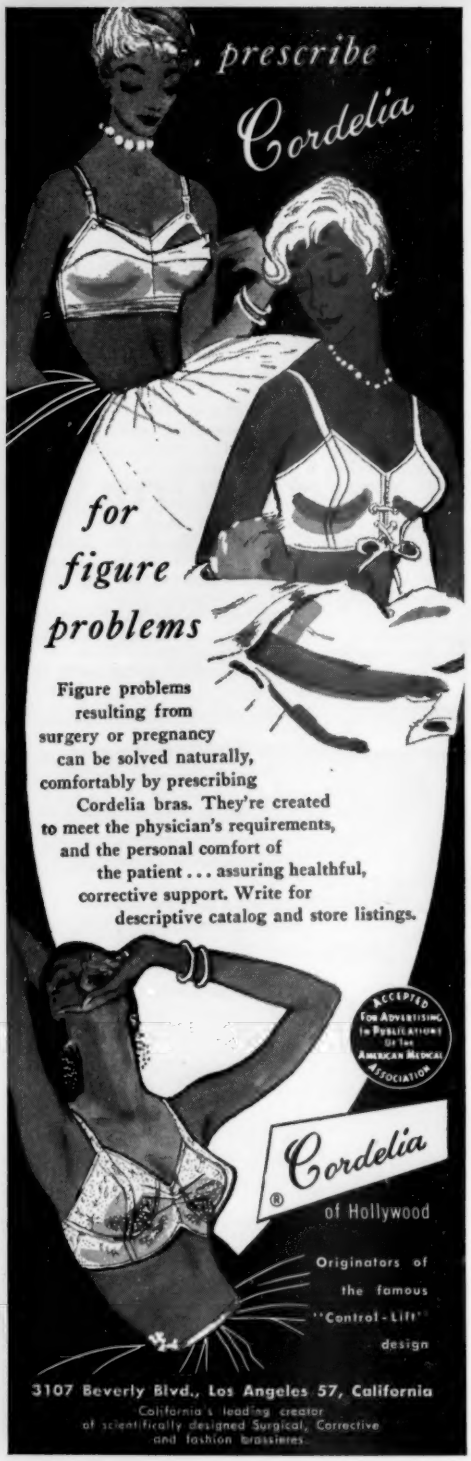


change in the State Health Code, Section 26-15-79. It is primarily an enabling act passed by the Legislature which allows a certain amount of enforcement to be put on recalcitrant TB patients and it is listed as a communicable disease. It allows certain homes to be set up, if they are approved by the State Board of Health, where patients could be sent in lieu of using beds in Ogden; these people could be confined in such a home.

It also states if on a complaint to the Board of Health these people are found to be tuberculous or carry a contagious disease, the County Attorney can act on the grounds that this is a misdemeanor. It also allows a lot of other things. It allows the religious cults and groups, if they have some strong feeling against certain medical treatment, to maintain their own homes as long as they are isolated. That has something to do with Christian Scientists who actually don't recognize it. And it puts teeth to allow collection. The Reference Committee recommends acceptance of this Report of the Committee on Tuberculosis and Cardio Vascular Diseases.

Dr. Hatch: Second the motion.

Dr. Brooke's motion carried unanimously.

Dr. Brooke: The next Committee report is that of the Committee on Sewage and Water Pollution, Dr. Leymaster's Committee. We recommend acceptance. We also ask that all of you read it and encourage those around you to read this report which deals with sewage and water pollution, and also the material that was sent out to all members of the Society. Actually, the bill passed by the Legislature gives power to the Water Pollution Control Board which has been meeting often. It recently asked Heber and will ask Salt Lake to submit plans to clear up danger spots in their sewage and water systems. This Board also prevents foolish use of funds for "oversold" equipment or equipment which may not meet standards of the engineering specialists. We recommend acceptance of this report.

Dr. Ruggeri: Second the motion.

Dr. Brooke's motion carried unanimously.

Dr. Brooke: The third committee report is the Report of the Public Health Committee by Dr. Jenkins. Our Committee accepts this report but calls attention to a statement which will meet your eye, that this Committee recommends routine chest films for all hospital admissions. Now in view of what has come up here in which we pointed out the increased cost of hospital care, this may occasion some comment.

There are two sides to it. The request of the Public Health people for something like this is based on the fact that nationwide studies have shown plus or minus 3 per cent of the people admitted to hospitals will show some sign of tuberculosis, suspicion of activity. I am told in Utah this would be plus or minus 1 per cent. But the question therefore is, are we, as doctors and nurses and so forth, in contact with people who may spread TB to us and to others in the hospital? If so, that is an argument for routine chest films. Just how important it is in Utah, I don't know.

In looking into it further, if units were bought, these small x-ray units which would cost around $7,000, the cost of a plate of a small type is around five cents per plate. Some people have said you could do this for as low as $1.00 per film. Dr. Kerby before his death looked into this and I understand at St. Mark's his estimate was it would be around $5.00 per rountine chest film. Be that as it may, this statement by the Committee is rather a statement of intent and a wish

to do something about it. I recommend acceptance of this report.

Dr. Dewey: Second the motion.

Dr. Brooke's motion carried unanimously.

Dr. Brooke: Our Committee next dealt with the Report of the Committee on Mental Health, Dr. Hardin Branch, Chairman. We recommend acceptance of this report with the proviso, however, that further study be given to clarify the legal status of the so-called Lobotomy Board which is suggested there. We as a committee felt that further information should be at hand as to its official recognition by the groups having a connection with the Lobotomy Board, and ways of compensating its members so that no criticism might prevail in this regard. Another question comes up on the Lobotomy Board: How wide is the geographical distribution it should have? Should it have access to Price and Provo, and so forth? We feel a question of suits and so forth enters into a Lobotomy Board as it does in some other things.

We recommend further study by the Council or by a committee appointed by the Council. We move that this report be accepted with that proviso.

Dr. Dewey: Second the motion.

Dr. Brooke's motion carried unanimously.

Dr. Brooke: The next was the Rural Health Committee, Dr. Reed Farnsworth, Chairman. This committee report was well done. It is outside the realm of some of our thinking; but in the way we could check upon this, we felt it to be acceptable. We recommend its acceptance with no suggestions.

Dr. Malouf: Second the motion.

Dr. Brooke's motion carried unanimously.

Dr. Brooke: Next is the Report of the Cancer Committee, Dr. John Carlquist, Chairman. The Committee recommended acceptance of this report, and as an aside, we discussed the question of why the cancer registry was illegal. As far as our committee discussed it, we believe this to be true. The reason why a cancer registry is illegal and other registries are legal would seem to imply that unless there is a contagion or serious danger to others, such as occurs in the polio report or the streptococcus report or most any of the other things that go around immediately, one cannot do so without being subject to violation of the patient's privacy. You apparently have no right to turn in a cancer report with the patient's name on it under present laws; and, therefore, Dr. Carlquist said they had to drop this cancer registry as so formed until further legal studies could be made. At the present time the feeling is it is illegal; and if the doctor reports any, he is subject to a suit.

We recommend acceptance of the Cancer Committee's report.

Dr. Eliot Snow: Second the motion.

Dr. Brooke's motion carried unanimously.

Dr. Brooke: Next is the Report of the Committee on School Health, Dr. Robert Rothwell, Chairman. The Committee recommends that this report be accepted. In essence, this report referred to—you see it in your brochure, it is actually twelve pages or more—it does briefly analyze and it puts into the hands of the private doctor the right to make public school examinations and it believes that these should be paid for by parents except where the patients, the children, are indigents, and then a mechanism is set up for these preschool examinations to be paid for. It says, however, as presently done these examinations are not acceptable because they


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are done very sketchily, they are inadequate in many ways, and they recommend that a standard form be put out for guidance. This is a big subject, however, and further study is being done.

The study in this state as I understand is modelled after the Wisconsin plan, the brochure that was sent around to the school authorities as well as the doctors.

The Committee sees nothing to object to in this report and recommends that further study, which is going on, be continued.

Dr. Beech: Second the motion.

Dr. Brooke's motion carried unanimously.

Dr. Brooke: I am glad to see Frank Winget is here because this last report is controversial in a way, which I know will initiate discussion. We commend Dr. Winget's group on a thorough study of the industrial health problem in Utah. We as a Reference Committee agreed with the principles recommended by the National Council on Industrial Health and Dr. Winget's suggestion that the field of industrial medicine should be emphasized in medical schools more, that there should be a better group of men engaged in industrial medicine and related problems in Utah. We felt that highly commendable. Our first reaction was to object to the next to the last paragraph of the report, but on further study we believe it to be right. First of all, if you look at the question of paying the doctor $25 for a session of the Medical Advisory Council, it may be innocuous to some of you, because so far in the past there has been no pay. On the other hand, the situation in the past has not been good; the Commissioner has objected to it, the fact that the men appointed didn't show up, and for other reasons it wasn't a good system. Therefore, we have felt that $25 should be paid to qualified doctors serving on the Medical Advisory Council, if the money does not come from the insurance carriers, that it isn't a prorater fund of the insurance carriers, but comes from a so-called nonpartisan fund from legislative action and the Industrial Commission. I can't give you the exact intricacies of the financing but this would be true, the money paid to the doctors would not be from the insurance carrier.

So with these explanations of why we accepted the report, I move that the Industrial Health Committee's report be accepted, and call on Dr. Winget, if he would care to act as a second and discuss the report.

Dr. John Z. Brown: Second the motion.

Dr. Frank Winget: I wish to discuss the problem of the Medical Advisory Council to the Industrial Commission. I am sure there are some men in the group who do not know what it is or the purpose of the committee. The Industrial Commission is a referee board for controversial cases either from the standpoint of the injured patient or the doctor or the insurance carrier. In these controversial cases, the Commission may find that a doctor has suggested a certain percentage of disability or loss of function of an injured part of the body, the insurance carrier or the patient may disagree with this; hence, some medical advisory council is needed to help settle these cases.

The Commissioner tells me that many times he finds injured patients with injuries, for in-

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stance, to the hands or feet, where the maximum improvement has not been attained and wherein if further and proper treatment were instituted a lesser degree of permanent disability could be attained. But the Commissioner feels it would be improper for him to suggest further treatment in such cases, but the Advisory Council could offer suggestions to the attending doctor for further treatment of the condition. He feels in his mind we should have an Advisory Committee with a better foundation of the problem concerned and who are interested in handling this most worthy undertaking in industrial medicine.

The Commissioner attended a meeting of the State Executive Council, to which I was invited, and presented this problem to the State Medical Council. He said he had been disappointed with the help given by men appointed of late and their lack of interest and the fact that in many instances the doctors failed to show up when the meetings were being held. He felt it against the diginity of the profession and the dignity of the other people at the hearings to have such a condition exist. He stated that he would have to have more qualified men and more cooperation in the Council.

Dr. Castleton gave our Committee the job of finding men for this Council who are qualified and interested and who will lend the dignity to the profession that the Commissioner desires. The Committee has met several times to discuss the problem.

We are presently listing a panel of men from which this Advisory Committee will be appointed. The list will be enlarged as men are contacted who show interest and are qualified to act in this Council. In the past, men from outlying districts have refused or have shown no interest in an appointment to this Council. Hence, up until the present time, the doctors in the Salt Lake area have been the only ones appointed. I do not think this is the right procedure. Every industrial area in the state should be represented at one time or another in the Council, but they should be men who are interested in industrial medicine and are cognizant of problems concerned.

We feel that men who are appointed to this Committee should be paid for their services since it entails much of their time. The State Industrial Commission has been given permission to pay the doctors $25.00 per each morning session and travel expenses at six cents per mile for the out-of-town doctors. If any doctor's judgment should be influenced by receiving this money, I feel he should not serve on the Committee.

The American Medical Association and our Committee feel that men interested in industrial medicine should serve on this Committee.

Dr. Brooke's motion carried unanimously.

Dr. Brooke: I would thank this Committee of Drs. Reichman, Brown, Nelson and Rees for their work, and as a final thing, recommend acceptance of Reference Committee No. 4's report as a whole.

Dr. Dean Spear: Second the motion.

Dr. Brooke's motion carried unanimously.

President Castleton: I would like to thank the Chairman and members of all four of these Reference Committees; they have done an excellent job. I would like to thank particularly Dr. Johnson, Dr. Matthei, Dr. Ruggeri and Dr. Brooke.

I have been wondering if we should have a Nominating Committee for this organization in the future for such offices as the general officers. I am told that in Colorado, for instance, they have such a Committee and they select men that


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they think might be interested or might be good men for Councilor from such-and-such a district. They go to him and ask him if he is interested in the job and if he is willing to devote the necessary time to it before his name is even proposed. This is simply a thought, but I think it is highly important to elect men who are willing to serve and take the time and effort necessary to do a good job, because these jobs have become complicated and time-consuming.

Dr. Robert Snow: I make a motion that the President of the Association shall, three months prior to the Annual Meeting of the House of Delegates, appoint a committee of five members who shall nominate two members of the State Association for each of the following offices: President-Elect, Honorary President, Delegate to the A.M.A., Secretary and Treasurer.

Dr. Matthei: Second the motion as Chairman of the Committee.

President Castleton: Someone might raise opposition to such a procedure as undemocratic, that it is better to have nominations from the floor.

Dr. Matthei: That still will leave it open for nominations from the floor as well.

Dr. Robert Snow's motion carried unanimously.

Dr. R. D. Beech: I would like to ask how the House of Delegates is going to instruct that committee to take care of the geographical pattern as previously followed in election of the President?

President Carlson: We have nothing in the Constitution to cover that. It has been a rather time-honored custom, however, to alternate between a President from Salt Lake City, or at least a member of the Salt Lake County Medical Society, one year, and the following year a President from outside the Salt Lake County Medical Society. We will proceed to the election of officers.

The following officers were then elected:

**President-Elect—Charles Ruggeri, M.D.**

**Honorary President—Jos. R. Morrell, M.D.**

**Treasurer—James R. Miller, M.D.**

**Delegate to A.M.A., 1954 and 1955—George M. Fister.**

**Alternate Delegate to A.M.A., 1954 and 1955—Eliot Snow, M.D.**

**Member of the Rocky Mountain Medical Conference Continuing Committee—Robert G. Snow, M.D.**

President Castleton appointed Drs. Dean Spear and Dorman to escort the incoming President, Dr. Bartlett, to the rostrum, and Dr. Bartlett delivered his incoming President's Address.*

The House then voted to hold the 1954 Annual Meeting jointly with the Ogden Surgical Society in May, and the 60th Annual Meeting of the House of Delegates in September.

The annual meeting then adjourned at 5:15 p.m., September 9, 1953.

*To be published separately in a subsequent issue.

## *Obituary*

### ARCHIE LEE BROWN

Dr. Archie Lee Brown of Salt Lake City, Utah, died Saturday, September 19, 1953, after a long illness.

He was born in Ogden, February 27, 1894. He attended the University of Maryland and Jefferson Medical College, Philadelphia, from which he received his medical degree in 1908. He completed postgraduate work in the London General Hospital and Moorefield's Eye Hospital, England,


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in 1910 and later did postgraduate work at Polyclinic Hospital, Philadelphia, and Ohio, New Mexico, Washington and California. He interned at Roosevelt Hospital, Philadelphia, and the Latter-Day Saints Hospital, Salt Lake City.

Dr. Brown began his practice in Bountiful, Utah, later serving as Box Elder County Physician. During World War I he served in a New York hospital and returned to Salt Lake City in 1918 to begin the practice of pediatrics. Later he established the Broadway Clinic.

He was a member of the Salt Lake County Medical Society and the Utah and American Medical Associations. He was an active member of the Church of Jesus Christ of the Latter-Day Saints.

Dr. Brown is survived by his widow and four sons and four daughters.

## *Auxiliary*

### CONVENTION NOTES

Mrs. A. M. Okelberry, President of the Woman's Auxiliary to the Utah State Medical Association, presided at a most successful convention of the State Auxiliary held in conjunction with the Rocky Mountain Medical Conference, at the Hotel Utah in Salt Lake City, September 10, 11, 12, 1953.

Mrs. Okelberry reported that the State Auxiliary organizations were planning a full year of cooperation with other groups in sponsoring the adopted project of the year 1953-54, "Safety." This project was suggested by the President of the Medical Association, Dr. Frank K. Bartlett.

Mrs. Leo J. Schaefer, National President, honored us with her attendance at the convention. She gave a most inspiring message at the opening session, stressing the national slogan, "Together We Progress." She also was guest at the various social functions.

We extend our sincere appreciation for her visit.

The "In Memorium" for Mrs. Silas S. Smith, one of our dearly beloved Past Presidents of the State Auxiliary, was beautifully conducted by Mrs. John Z. Brown, Sr., a past State President. This was an inspiring tribute to an honored, departed member.

Reports of state officers and County Presidents were presented in the form of plans and suggestions for the coming year. All urged participation in Nurse Recruitment Program, subscription to the Bulletin and "To-Day's Health."

Salt Lake County Auxiliary was hostess to a delightful Luncheon-Fashion Show, at the Hotel Utah, following the opening session of the convention.

Mrs. Dean A. Moffat, the Salt Lake County President, welcomed some 300 members and guests of the Auxiliary. She announced that this served as the opening for the activities of the year. Mrs. Roy A. Darke, the Salt Lake County Auxiliary Program Chairman, was in charge of this most entertaining affair.

The Patio Party at the residence of Dr. and Mrs. Reed Clegg was enjoyed the same evening by members and guests.

Friday morning the ladies were entertained

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at beautiful Brighton Lodge. In the afternoon a large group enjoyed the special organ recital at the L. D. S. Tabernacle.

The convention was a means of renewing friendships—an inspiration to "carry on" with the objectives of the Auxiliary and to again pledge our loyalty to a group of efficient National and State officers.

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## WYOMING
## State Medical Society

### *1953 Licentiates*

The Wyoming Board of Medical Examiners has announced the list of new Wyoming licenses to practice medicine issued at the three meetings of the Board held during 1953. As of mid-October, twenty-nine physicians were newly licensed in the year, including nine who are practicing outside Wyoming. The twenty who have located in Wyoming are:

Patricia Mary Kamsler, Cheyenne; Albert E. Currier, Sunrise (temporarily in military service); Lee K. Buchanan, Superior; Benjamin M. Leeper, Cheyenne; Spencer Walton, Newcastle; Richard C. Baughman, Gillette; Duane M. Kline, Cheyenne; Donald R. Daines, Evanston; Orin R. Hayes, Cheyenne; Robert V. Plehn, Gillette; Walter R. Cockley, Laramie; F. Burton Graves, Sheridan; Joseph R. Volk, Jr., Torrington; David W. Gregg, Sunrise; James W. Reichard, Lander; Robert D. Knapp, Jr., Pinedale; Frederick F. Young, Kemmerer; John H. Froyd, Northwestern; William J. Norman, Pinedale, and Robert Roy Sprowell, Superior.

## NEW MEXICO
## Medical Society

### *Obituary*

CASH C. RAMEY, JR.

Cash C. Ramey, Jr., M.D., Portales, New Mexico, died in his sleep of a heart attack, October 10, 1953.

He was graduated from Rush Medical College in 1942 and interned at Presbyterian Hospital in Chicago.

Dr. Ramey served four years in the Army Medical Corps during World War II. He participated in five major campaigns in the European Theater and received several decorations, including the Purple Heart for serious wounds received in action on Christmas Day, 1944.

Dr. Ramey began his practice in Portales in 1947. He was a member of the Roosevelt General Hospital staff in Portales, Curry - Roosevelt County Medical Society, New Mexico Medical Society, and the American Medical Association.

Dr. Ramey is survived by his wife and three small daughters.

## *The Book Corner*

### *New Books Received*

**Managing Your Coronary:** By William A. Brams, M.D., Senior Attending Physician at Michael Reese Hospital, Chicago; illustrations by Hertha Furth. J. B. Lippincott Publishers, Philadelphia, Pa. Price, $2.95.

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**Synopsis of Pediatrics:** By John Zahorsky, A.B., M.D., F.A.A.P., Professor Emeritus of Pediatrics and formerly Director of the Department of Pediatrics,


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**The Nursing Mother, a Guide to Successful Breast Feeding:** By Dr. Frank Howard Richardson, the author of nine books on Parenthood. Prentice-Hall, Inc., New York. Price, $2.95.

## BLUE CROSS and BLUE SHIELD

The trouble with the Garden of Eden was over-utilization—one apple too many. With Blue Cross it is a crate-full of apples too many. People yield to their temptations and they indulge in the comforts of hospital care when they should be home again. Though Colorado has about the highest utilization in the country, the abuse is widespread. We quote from the Nebraska State Medical Society Journal,* which in turn quotes from the North Carolina Medical Journal:

"About a year ago, I became interested in the question of Blue Cross abuse by physicians. I made a rather cursory study of the situation in our hospital, a 185-bed institution. The results were revealing. I found that there were twenty-six patients who had been in the hospital two weeks or longer. Of these twenty-six, nineteen had Blue Cross coverage. I studied the charts of these nineteen carefully, and in my opinion only three had, by any stretch of the imagination, a good reason to be in the hospital, and all sixteen remaining were ambulatory.

"Five were patients with casts of some sort for fractures; several were waiting for cast changes and x-rays checks a week or ten days hence. Three were diabetic patients under control, two of whom were there because they felt they had no better place to go. Two were ambulatory cardiac patients, well compensated. One had had a tonsillectomy and was later to have a hemorrhoidectomy. Two were postoperative patients getting dressings every other day. One was receiving x-ray treatments for a sub-acromial bursitis. One was a man 80 years old who was irrational, and had been brought in because the family wanted to spend a Merry Christmas without the trouble of having grandpa around. One had a cirrhosis of the liver and was having a paracentesis done every ten days. One had so-called rheumatoid arthritis, and was being treated with cortizone.

"This last case was, too, the most flagrant instance of abuse on record. The physician had unwittingly documented it perfectly and signed it. He had written ten orders for leave of absence from the hospital. One was to attend a banquet at the Statler Hotel and several were for entire weekends at home. This case cost Blue Cross $733.00 and Blue Shield $106.00. The patient was in the hospital thirty-two days.

"After gathering this information, I went before a staff meeting the following day with some rather pertinent statements. By noon, we had fifteen discharges."

*February, 1953.


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1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.


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